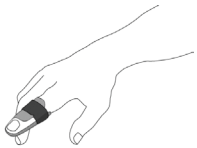
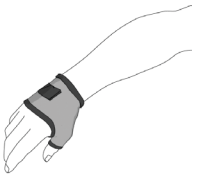


Appointment

Date

Time



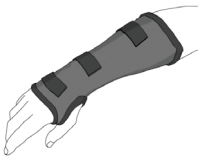
Patient Referral

Patient Name Date of Birth

Address

Telephone

Private Health Cover? (Please Circle) Yes No

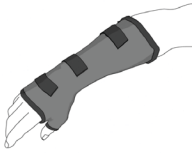


Membership Number

W/C MVIT

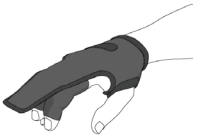
Claim Number

Diagnosis



Treatment

Splint Required



Precautions / Special Instructions

Surgical Specialist On Referral Required? Yes No

Referring Doctor Date

inhand occupational therapy

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