

JCUHealth EXERCISE PHYSIOLOGY CLINIC REFERRAL FORM

Please complete and submit this form by email, fax or deliver to JCUHealth Reception



Level 1, Clinical Practice Building
1 James Cook Drive
James Cook University QLD 4811

PO Box 217
James Cook University QLD 4811

Phone 07 4781 4495
Fax 07 4779 2739

ABN 15 099 496 232

Date _____

Patient First Name:	
Patient Surname:	
Patient DOB: / /.....	<input type="checkbox"/> Male <input type="checkbox"/> Female

Address of Client: _____

Suburb: _____ City: _____ P/code: _____

Phone: Home _____ Mobile _____

Email: _____

Is it acceptable to leave a message on home phone? Yes No or mobile phone? Yes No

Diagnosis:.....

Request:.....

Special Considerations:

Where possible, please provide supporting documentation e.g. X-Rays and/or medical reports (this can be provided by the client at time of appointment) Will you be bringing supporting documents to first appointment? Yes No

Referrer: Self Other Name: _____

Practice: _____ Address: _____

Phone No. _____ Mobile: _____

Email: _____

Referrer signature : _____ Date..... / /.....

If future liaison is required, please indicate your preferred method for providing information about your client's progress:

- Initial Assessment Report Discharge outcome summary
 Progress report at weeks/months. Brief discussion using either email or phone.

Please indicate how you would prefer to receive a report: Email Fax Mail