LASER PAIN THERAPY - REFERRAL FORM

Copies available at [https://laserpaintherapy.com.au](https://laserpaintherapy.com.au/contact/)

**Email to:** [**info@laserpaintherapy.com.au**](mailto:info@laserpaintherapy.com.au) **or Fax to 03 8528 8762**

Your patient will be contacted by phone and/or email to arrange an appointment and will also receive a phone call from our senior laser therapist. For all enquiries please telephone (03) 8529 2225

# Patient details

Surname: Given names:

Date of birth: Sex: Male □ Female □

Address:

Preferred contact number: Mobile\*: Email\*:

Medicare number#:

**\* Mobile number used to send SMS reminder before appointment and email to send clinic location information. # Needed for billing to Medicare**

# Clinical details

Reason for referral / diagnosis:

Treatments to date:

Please include any relevant pathology and imaging results with this referral.

Further Notes (Past Medical History, Medications etc.):

# Referrer details

Surname: Given name:

Provider number: 

## Practice stamp (if available)

Address:

Telephone number:

Fax number:

**Signature**:

Date:

Preferred contact: □ Telephone □ Fax □ Email: 