



**Patient's Information**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Medicare Number: \_\_\_\_\_

**Clinical History/Medication**

Presenting Diagnosis: \_\_\_\_\_

Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Other Medical Conditions: \_\_\_\_\_

- Has the patient exhausted all other treatment options? Yes  No
- Does the patient have a history of unstable serious mental illness? Yes  No
- Does the patient have a history of cardiovascular disease? Yes  No
- Does the patient have a history of drug or alcohol abuse? Yes  No
- Is the patient pregnant or intending to fall pregnant? Yes  No

**Referring Doctor's Details**

Doctor's Name: \_\_\_\_\_

Provider Number: \_\_\_\_\_ Qualifications: \_\_\_\_\_

Practice Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Healthlink EDI: \_\_\_\_\_

Referral Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please attach any specialist letters, results or other relevant clinical records for the treatment of your patient.

Please attach past prescription history for the last 2 years.