Emerald Clinics
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Fax: (08) 6559 2829
1300 436 363

Patient 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.