Emerald Clinics
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www.emeraldclinics.com.au
1300 436 363

## Patient's Information

Name: _____ Date of Birth: ___/___/___

Address: _____

Mobile Phone: _____ Home Phone: _____

Medicare: _____ DVA: _____

### 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 |
| Would this patient be interested in joining a clinical trial? | ☐ 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.**