REFERRAL FORM

NAME:		D.O.B	

ADDRESS:	

MEDICAL HISTORY (INC. ALLERGIES, MEDICATIONS AND PREVIOUS STI):	

Phone: (HM)		(WK)		(MB)	

Email:	

Does the client have Medicare?	YES / NO

DETAILS OF SERVICE/S REQUIRED

THIS REFERRAL HAS BEEN AGREED UPON BY CLIENT			
Client sign :			
Health Professional sign :		**Date :**	

<table>
<tr><td colspan="4">THIS IS A REFERRAL SUBMITTED BY AN ORGANISATION ON BEHALF OF A POTENTIAL CLIENT</td></tr>
<tr><td>NAME OF ORGANISATION</td><td colspan="3"></td></tr>
<tr><td>NAME OF HEALTH PROFESSIONAL AND SIGNATURE</td><td></td><td>Date of initial referral :</td><td></td></tr>
</table>

DISCLAIMER: We take privacy very seriously at M Clinic and LinQ Medical. When sending this referral form, all necessary confidentiality measures need to be adhered to.

Our preference is sending through **email** in a **password protected document**.

Please email your referral through to **Joe Staniszewski** (Practice Manager) at jstaniszewski@waaids.com with the title of the email being **EXTERNAL REFERRAL OF SERVICES**

Please inform us of the password of the document in either a separate email or through other correspondence

If you have any questions please do not hesitate to call M Clinic/LinQ Medical on (08) 9227 0734 within operating hours.