Exercise Physiologist Referral Form

Send referral to: Email: reception@boabhealth.com.au | **MMEx:** "Boab Health Allied" | **Fax:** 9192 7999

*** Please inform the client the reason for referral & benefits for attending their allied health appointment**

First name:	**Surname:**	**DOB:**
☐ **Aboriginal origin only** ☐ **Aboriginal & Torres Strait Islander** ☐ **Torres Strait Islander origin only** ☐ **Unknown Indigenous status**		**Gender:** ☐ F ☐ M ☐ Non-binary ☐ Transgender ☐ Intersex ☐Prefer not to say ☐ Other:_________
Mobile:	**Tel** (other):	**Email:**
Address (House number/street):		**Postal / PO Box:**
Town/community:		**Post code:** **State:**
Clients support person: ☐ Yes support person contact details: **Name:** **Tel:**		
Medicare No.: ☐☐☐☐☐☐☐☐☐☐ ☐ (ref. no.) **Exp. Date:** ☐☐ / 20 ☐☐		**Main language spoken** (if other than English): **Is an interpreting service required?** ☐ Yes ☐ No
If complete, tick and attach: ☐ GPMP Date: ☐ Health Assessment (715) Date:		

Reason for referral. *Note, the more information you provide here, the more helpful to our clinicians & clients.*

☐ Increase Physical Activity Levels
☐ Chronic Condition of concern: ______________________________
☐ Pain Management
☐Musculoskeletal Injury
☐ Mental Health
☐ Social and Emotional Wellbeing
☐ Other (pls specify):

Please provide any additional information/cultural considerations:

Tick & attach the following client records with this referral (required for accurate triage & treatment):

☐ Relevant medical history & allergies
☐ Pathology / investigations including:
- ☐ Hba1c
- ☐ Total Cholesterol
- ☐ HDL

☐ Current medications including dosage
☐ Type of Referral:
- ☐ Individual Allied Health for chronic medical conditions (10953)
- ☐ Individual Allied Health for Aboriginal and Torres Strait Islander People (81315)

☐ **I have obtained consent from the client / legal guardian to provide their personal health information to Boab Health Services.**

☐ **This client is safe and cleared to participate in physical activity or exercise.**

Referrer details

Referrer Name:	**Provider No:**	**Phone:**
Organisation:	**Email:**	**Date:**
Signed:		