Referral Form for Adelaide University Health Clinics

Student-led or clinician-led services

Date:	Referring Clinic/Practice:

Referrer Details	
Name	
Address	
Phone	**Provider No.**
Fax	**Signature**

Patient Contact Details		
Title:	**First Name:**	**Surname:**
Address:		
Contact Phone:	**Date of Birth:**	

Which clinic/service are you referring to?

Service Type

- ○ Physiotherapy
- ○ Podiatry
- ○ Exercise Physiology
- ○ Occupational Therapy
- ○ Psychology
- ○ Social Work
- ○ Speech Pathology
- ○ Other:_____

Preferred Location

- ○ Elizabeth
- ○ City West Campus
- ○ City East Campus
- ○ Magill Campus

Reason for Referral

Supporting Information
Relevant Medical History
Medications
Allergies
Diabetes/Chronic Illness
Other relevant Information

Fax completed form to **(08) 8302 7888** or email auhealthclinics@adelaide.edu.au

Please contact the clinics directly for current pricing and service information auhealthclinics.com