INTEGRATED HAND INJURY CLINIC referral form

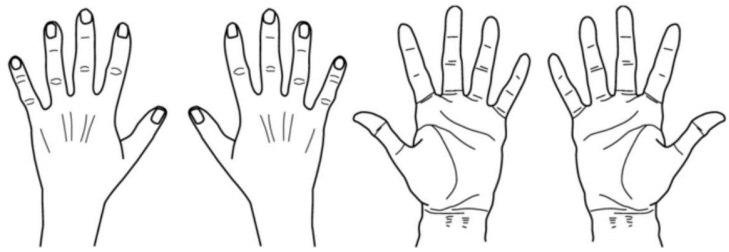
1 Suttor Place, Figtree NSW 2525, Phone 1300 009 555, Fax 02 8214 5860

PLEASE FAX THIS REFERRAL TO US, CALL IF ANY QUESTIONS
REFER TO OUR PROTOCOL FOR DETAILED REFERRAL INSTRUCTION

PATIENT DETAILS

NAME (or patient label)	
DOB / MRN	
PHONE (mandatory)	
COMMORBIDITIES	
MEDICATIONS	
ALLERGIES	
TETANUS VACCINATION (administer prior to referral)	CURRENT? DATE ADMINISTERED NA (closed injuries) YES NO
ANTIBIOTIC ADMINISTERED	YES NO NAME OF ANTIBIOTIC NA (closed injuries)

INJURY DETAILS

LOCATION	
DATE / TIME	
INJURY DESCRIPTION (Please note: X ray must be performed prior to referral to us.)	

REFERRAL

REFERRING DOCTOR	NAME & PROVIDER NUMBER SIGNATURE LOCATION
FOR URGENT REFERRALS	DISCUSSED WITH
PATIENT INFORMATION SHEET GIVEN TO THE PATIENT	YES NO