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General Referral

PATIENT DETAILS

Patient name:

Birth date:

Contact details:

Medicare number:

WorkCover claim number:

EXAMINATION REQUESTED

Referring for consultation and management of patient with osteoarthritis, and for consideration of EUFLEXXA

CLINICAL DETAILS

Contrast allergy ☐ No ☐ Yes

Renal impairment ☐ No ☐ Yes eGFR _____

Pregnant ☐ No ☐ Yes ☐ Unsure ☐ Not Applicable

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Contact details:

Provider number:

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Signature Date

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General Referral

PATIENT DETAILS

Patient name:

Birth date:

Contact details:

Medicare number:

WorkCover claim number:

EXAMINATION REQUESTED

CT guided EUFLEXXA injection

CLINICAL DETAILS

Contrast allergy ☐ No ☐ Yes

Renal impairment ☐ No ☐ Yes eGFR _____

Pregnant ☐ No ☐ Yes ☐ Unsure ☐ Not Applicable

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