

UQ Healthy Living Referral Form

Ph: 07 3443 2586 | Fax: 07 3319 6583
uqhealthyliving@uq.edu.au

Date:

Thank you for seeing _____ for the reason/s indicated below.

Client Details:

Name:

D.O.B:

Address:

Referrer Details:

Name:

Address:

Phone:

Fax:

Requested service:

Exercise Physiologist

Physiotherapist

Dietitian

Cardiac rehabilitation / maintenance

Pulmonary rehabilitation

**For Medicare referrals, please include a copy of the GPMP and Medicare Enhanced Primary Care referral.*

Reason for referral:

Medical history:

Recent test results (as appropriate):

Medications:

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