Office use only.

Referral number: _____
Date received: ___ / ___ / _____

Fax: 08 6444 7400

Suite 2, 283–285 Unley Road, Malvern, SA, 5061.
Ph.: 0479 147 400

admin@**kurmis**orthopaedics.com.au
www.kurmisorthopaedics.com.au

Day /_Month_ / 202__.

Attention: A/Professor Andrew Kurmis – Specialist Orthopaedic Surgeon.

Dear Andrew,

Thank you for accepting the care of _____patient's full name_____ (dob: ___ /___ /_____).

Medicare number: _____ ( ) expiry date: _____

Private Health Insurer: _____ Membership number: _____

Home address: _____ postcode: _____

Mobile: _____ Phone number: (08) _____

e-mail address: _____

age: _____ years height: _____ cms weight: _____ kgs BMI: _____

Imaging performed at: _____ date: ___ / ___ / _____

Main problem(s): pain / poor function / injury / other: _____

Joint(s) involved: hip(s) right / left / bilateral

knee(s) right / left / bilateral

other: _____

Principal diagnosis / concern: _____

_____

_____

_____

Previous surgery(ies): _____

_____

_____

Office use only.

Practice ID number: _____

Office use only.

Referral number: _____
Date received: ___ / ___ / _____

Past medical history: _____

_____

_____

_____

_____

_____

_____

Allergies: _____

Current medications: _____

_____

_____

_____

_____

_____

_____

Please do keep me informed as to your future successes in the management of this patient.

Yours sincerely,

signature

Dr. _____Referrers name (printed clearly)_____

Provider number: _____

Practice name: _____

Practice address: _____

Office use only.

Practice ID number: _____