

UQ Healthy Living Referral Form

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Date:

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

Client Details:

Name: D.O.B:

Address:

Phone number: Email:

Referrer Details:

Name:

Address:

Phone: Fax:

Requested service:

- Exercise Physiologist
- Cardiac rehabilitation / maintenance
- Pulmonary rehabilitation
- Physiotherapist

**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: