Exercise Physiology Referral

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ACTIVERX

REFERRING PRACTITIONER DETAILS

Referrer Name		Provider Number	
Email		Phone	
Practice name		Date	

PATIENT DETAILS

Full name			
Date of birth			
Email		Phone	

FUNDING TYPE (tick one)

☐ Private ☐ DVA ☐ Medicare EPC/CDM ☐ NDIS ☐ WorkCover ☐ Other _____

DVA DETAILS (if applicable)

DVA file number		Card type	☐ Gold ☐ White
Accepted condition / sessions			

MEDICARE EPC / CDM (if applicable)

EPC date		Sessions requested	

NDIS DETAILS (if applicable)

NDIS number		Plan type	☐ Self ☐ Plan ☐ NDIA
Plan manager / sessions			

WORKCOVER DETAILS (if applicable)

Claim number		Insurer	
E(mployer / injury date / sessions			

REASON FOR REFERRAL / DIAGNOSIS (e.g conditions, goals, precautions)

EP SERVICES REQUESTED

☐ Initial assessment ☐ Individual program ☐ Chronic condition ☐ Pain/Injury rehab ☐ Return to work ☐ Falls prevention ☐ Other _____

NUMBER OF SESSIONS / DURATION

☐ As clinically indicated ☐ Up to ____ sessions ☐ Valid for ____ months

☐ I consent to referral and sharing of relevant clinical information with ActiveRx Exercise Physiology