

**REFERRAL – Patient Details** (please print)

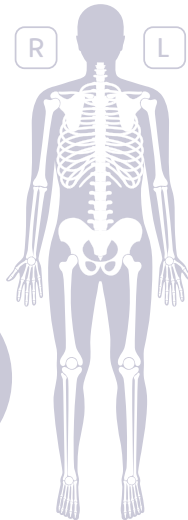
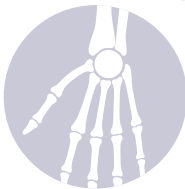
Given Name/s		Surname	
Phone (home)		Mobile	
Address		Medicare number	
Email			

**Condition**

Type:

- Fracture
- Injury
- Chronic

*Please indicate area of condition >*



**Insurance Details**

Private Health Insurance  Yes  No

Work Cover  Yes  No

Diagnosis/symptoms:

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Imaging performed:  XR  US  MRI

**Referrer**

Referring doctor

Provider number

Clinic/postal address

Email

Phone

*Referrals can be sent by fax 07 4422 0299, or email admin@aspire.com.au.  
The original should be given to the patient who will be contacted by us within 2-3 days.  
Referrals can also be submitted online at www.aspire.com.au.*

## RECOMMENDED IMAGING

	XR	US	MRI	NIL
<b>Shoulder</b>				
Chronic rotator cuff issues	▪			
Arthritis	▪			
<b>Hand and wrist</b>				
Chronic wrist and thumb pain	▪			
Joint deformity	▪			
Carpal tunnel				▪
<b>Hip</b>				
Acute injury/groin pain	▪	▪	▪	
Chronic hip pain and arthritis	▪			
Stiffness and decreased R.O.M.	▪			
<b>Knee</b>				
Acute injury and instability	▪		▪	
Chronic pain and deficiency	▪			
<b>Ankle</b>				
Instability	▪		▪	
Arthritis and chronic pain	▪			

## ACUTE INJURIES (FRACTURES)

Splint/backslab injury and call us immediately on 07 4426 1099.

**Dr Jonathon de Hoog** *Orthopaedic Surgeon*

☎ P: 07 4426 1099

☎ F: 07 4422 0299

✉ admin@aspireortho.com.au

🌐 www.aspireortho.com.au

