



Physical Activity and Lifestyle Programs

Referral Form

CHILD DETAILS

Name: _____ DOB: _____

Street Address: _____ Suburb: _____ Postcode: _____

Parent/Guardian Name(s): _____

Phone: (H) _____ (M) _____ (W) _____

Interpreter needed: Yes No Language: _____

Have you discussed this referral with the child and family ? Yes No

TREATING PROFESIONALS DETAILS (GP, Specialist, Allied Health Professionals)

Name 1: _____ Role: _____

Postal Address: _____ Suburb: _____ Postcode: _____

Phone: _____ Fax: _____ Email: _____

Name 2: _____ Role: _____

Postal Address: _____ Suburb: _____ Postcode: _____

Phone: _____ Fax: _____ Email: _____

Name 3: _____ Role: _____

Postal Address: _____ Suburb: _____ Postcode: _____

Phone: _____ Fax: _____ Email: _____

REFERRAL DETAILS

Referral submitted by (name): _____

Intensive program package*

Initial program assessment only

* (Initial and final program assessment, 16 supervised activity sessions, home-based activity program)

Specific goals of referral:

38 BOTANY STREET (CORNER BOTANY AND HIGH STREETS) RANDWICK NSW 2031

T. 02 9385 3352 F. 02 9385 3195 E. lifestyleclinic@unsw.edu.au W. www.lifestyleclinic.net.au

MEDICAL CONDITION / INJURY DETAILS

Provide specific details of the child's medical condition/injury

(diagnosis, date of occurrence, limitations, other relevant conditions/co-morbidities).

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Provide details of any relevant clinical indicators or outcome measures

(blood tests, physical or psycho-social assessment scales, functional capacity)

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Provide details of current medications

Heart Condition	
Diabetes	
Epilepsy	
Asthma	
ADD/ADHD	
Allergies	
Other	
Other	

* Please either complete this table or attach a list of medications to this referral.

Compensible Injuries Only	
Insurer Name: _____	Claim no: _____
Contact person: _____	
Postal Address: _____	Suburb: _____ Postcode: _____
Phone: _____ Fax: _____	Email: _____

PLEASE FAX TO (02) 9385 3195

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