

## Online GP Referral Form

### Patient Details

First name: \_\_\_\_\_

Surname: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Residential Address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Medicare Number: \_\_\_\_\_

### Information

Reason for Referral:

Relevant Medical History:

Current Medications:

### Referrer Details

Doctor's Name: \_\_\_\_\_

Provider Number: \_\_\_\_\_

Practice Contact Number: \_\_\_\_\_

Practice Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_

Please Fax or Email All Referrals to:  
Martin Room Suites  
F: (03) 9445 9189  
E: [lpbsurgery@gmail.com](mailto:lpbsurgery@gmail.com)