

**ADL Health Pty Ltd  
Compression Clinic Referral Form**

**3 Virgil St, HYDE PARK Q 4812**

**Ph: 47720066 FAX: 47240370**

**Doctor's details**

Referring doctor: \_\_\_\_\_ Practice: \_\_\_\_\_

Phone: \_\_\_\_\_ Facsimile: \_\_\_\_\_

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

**Patient details**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_



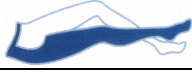


Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Diagnosis \_\_\_\_\_

**Garment details**

**PLEASE SELECT TYPE AND COMPRESSION LEVEL FROM THE FOLLOWING OPTIONS:**

- Ready to Wear Compression Garment, or
- Custom Made Garment

Type		Compression mm Hg				
		15-20	20-30	30-40	Open toe	Closed toe
	Knee					
	Knee with zip (ulcer care)					
	Thigh					
	Chaps					
	Waist					
	Maternity (pantyhose)					
	Other					

**ADDITIONAL COMMENTS:**

\_\_\_\_\_  
 \_\_\_\_\_

**DOCTOR'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

