Client referral form

Please select service required

- ☐ Colposcopy (Brisbane / Ipswich / Cairns)
- ☐ Vasectomy (Brisbane / Cairns)
- ☐ Menopause
- ☐ Menstrual problems
- ☐ Antenatal care
- ☐ STI Screening
- ☐ Contraception
- ☐ Implant-Implanon
- ☐ IUD-Copper
- ☐ IUD-Mirena
- ☐ Diaphragm
- ☐ Pap smear

Please select True clinic location

☐ **Brisbane**
230 Lutwyche Road, Windsor Q 4030
P 3250 0200 F 3250 0293

☐ **Cairns**
182 Grafton Street, Cairns Q 4870
P 4051 3788 F 4031 6017

☐ **Ipswich**
5/54 Limestone Street, Ipswich Q 4305
P 3281 4088 F 3282 7088

☐ **Rockhampton**
Glenmore Shopping Village
10-11/301-307 Farm Street
Norman Gardens Q 4701
P 4927 3999 F 4927 6003

☐ **Toowoomba**
661 Ruthven Street, Toowoomba Q 4350
P 4632 8166 F 4632 2365

Client details

Name	Date of birth
Address	
	Postcode / Email
Phone (M) / (H) / (W)	

Reason for referral

Please ensure that referrals are accompanied by the results of relevant investigations including cervical screening, pathology investigations and imaging reports.

Referrer details

Name
Surgery
Provider No.
Address for correspondence
Postcode
Phone
Fax
Email
Signature / Date

Practice stamp

Thank you for your referral.