# Monty Pelvic Physio

## Clinical Referral Form

**PRACTICE DETAILS**


- **Clinician:** Min Khoo (APAM) – Master of Physiotherapy Studies (UQ), Post-graduate Pelvic Health (UniSA / UniMelb)
- **Address:** 35 Were St, Montmorency VIC 3094
- **Phone:** 0411 570 626
- **Email:** info@montypelvicphysio.com.au | **Web:** montypelvicphysio.com.au


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## 1. REFERRING PRACTITIONER DETAILS

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|---|---|
| **Doctor Name:** | **Provider Number:** |
| **Clinic Name:** | **Phone/Fax:** |
| **Provider Number:** | |

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## 2. PATIENT DETAILS

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|---|---|
| **Full Name:** | **Date of Birth:** |
| **Phone Number:** | **Medicare Number:** |

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## 3. CLINICAL INDICATIONS (Please Tick)

**[ ] Menopausal Transition & Pelvic Wellness** (GSM, Osteopenia/Osteoporosis, Pelvic Floor Changes)

**[ ] Chronic Pelvic Pain** (Endometriosis, Adenomyosis, Vulvodynia, Vaginismus, Dyspareunia)

**[ ] Pregnancy Support** (Pelvic Girdle Pain, DRAM, Birth Preparation)

**[ ] Postpartum Recovery** (6-week check, DRAM, Return-to-Sport Screening)

**[ ] Men's Pelvic Health** (Post-prostatectomy, Urinary Incontinence, Chronic Pelvic Pain)

**Clinical Notes / Relevant Surgical History:**

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## 4. FUNDING & ADMINISTRATIVE

**[ ] Chronic Disease Management (CDM/EPC) Plan Attached** (Item 10960)

*Please ensure the referral is addressed to **Min Khoo** to facilitate the Medicare rebate.*

**[ ] Private Patient** (No referral required, but clinical notes appreciated)

**[ ] WorkCover / TAC** (Claim Number: _____)

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## 5. PRACTITIONER AUTHORISATION

**Signature:** _____ **Date:** _____/ _____/ _____