



# Hydrotherapy Referral

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

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

Reasons for referral

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Relevant past medical history

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Would you like regular updates on the progress of your patient? \_\_\_\_\_

Signed: \_\_\_\_\_

Name: \_\_\_\_\_

Clinic Stamp

# Capital Hydrotherapy

Assessment Rooms:

8/2 King Street

Deakin ACT 2600

[www.capitalhydrotherapy.com.au](http://www.capitalhydrotherapy.com.au)



## Appointment - Phone/Fax: 6156 2223

Time: \_\_\_\_\_ Date: \_\_\_\_\_



### Kings Deakin

Unit 17E

2 King Street

Deakin ACT 2600



### Kings Majura Park

29 Catalina Drive

Majura Park ACT 2609