

**REFERRAL FORM**Date of Referral: 

Selected Clinic Location:

 Baulkham Hills       Orange       Bathurst       PenrithFirst Name:  Surname: Date of Birth:  Sex:  Male  Female  OtherPhone No.:  Email: Address: Medicare Number:  Individual Reference Number (IRN): 

Payment / Funding:

 Medicare       DVA       Workers Compensation       MVAA       Privately Insured

Reason for Referral:

Please email/fax relevant medications, pathology and imaging results with this referral form.

Referrer Name:  Provider Number: Practice / Organisation Name: Practice Address: Practice Phone:  Practice Fax: Referrer Signature: **Baulkham Hills**Integrated Wellbeing Hub  
482 Windsor Road, Baulkham Hills  
Ph: (02) 8271 5000  
Fax: (02) 8271 5055  
info@integratedwellbeinghub.com.au  
Provider No. 428475MK**Bathurst.**WeCare Health  
185 Durham Street, Bathurst  
Ph: (02) 9094 3589  
Fax: (02) 9098 8759  
uniquepainreception@gmail.com  
Provider No. 428475NY**Orange**Bloomfield Specialist Group  
Level 5, 1521 Forest Rd, Orange  
Ph: (02) 9094 3589  
Fax: (02) 9098 8759  
uniquepainreception@gmail.com  
Provider No. 428475GF**Penrith**Western Pain Centre  
Level 1, 454 High Street, Penrith  
Ph: (02) 4721 3016  
Fax: (02) 4721 0015  
reception@westernpaincentre.com.au  
Provider No. 428475CJ