REFERRAL FORM

www.carpaltunnel.com.au

Carpal Tunnel Clinic

PATIENT NAME:

DATE:

PHONE:

DOB:

ADDRESS:

AFFECTED HANDS:

- ☐ Right
- ☐ Left

CLINICAL DETAILS:

- ☐ Numbness
- ☐ Pain
- ☐ Loss of Grip Strength

PLEASE ARRANGE:

- ☐ Consultation
- ☐ Nerve Conduction Study - Median Nerve
- ☐ Ultrasound-Guided Steroid Injection
- ☐ Consideration of Micro-Invasive Carpal Tunnel Release

NOTES:

STAMP:

REFERRER DETAILS:

☐ **URGENT CONSULTATION REQUESTED**

DOCTORS SIGNATURE:

CARPAL TUNNEL CLINIC

e: info@carpaltunnel.com.au
w: carpaltunnel.com.au