

# Referral for services



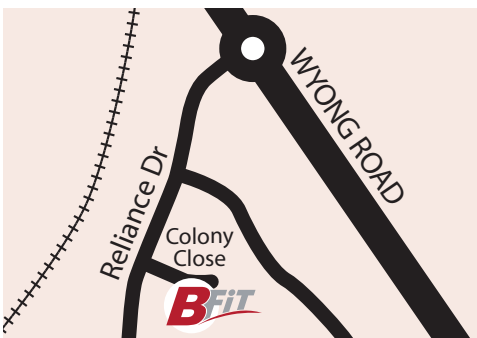
## Rehabilitation and Wellness Centre

- Accredited Exercise Physiologist (AEP)
- Exercise Therapists

<input type="checkbox"/> WorkCover	<input type="checkbox"/> Medicare	<input type="checkbox"/> Dept Vet Affairs	<input type="checkbox"/> Private Health Ins	<input type="checkbox"/> Private
Name:				DOB:
Address:				
Contact No:			Claim No:	
Insurance agent:				
Contact No:		Contact Name:		
Diagnosis:				

## Services/assessments required

<input type="checkbox"/>	Initial assessment (AEP)	<input type="checkbox"/>	Bfit to Work (work related activity program)
<input type="checkbox"/>	Exercise program/studio membership	<input type="checkbox"/>	EPC chronic condition program
<input type="checkbox"/>	Weight loss	<input type="checkbox"/>	Diabetes education/ex program
<input type="checkbox"/>	Active over-50 classes	<input type="checkbox"/>	Falls prevention classes
<input type="checkbox"/>	Exercise physiologist – DVA	<input type="checkbox"/>	Other (please advise)



## Referrer's details

Name:
Address:
Contact No:
Provider No:

P L E A S E   F A X   C O M P L E T E D   F O R M   T O   4 3 5 3   0 3 1 5



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