Referral Letter

MEDICARE CARD NUMBER
JCXXXX1232XXX21

hola

PATIENT LAST NAME	GIVEN NAME	SEX	DATE OF BIRTH	YOUR REFERENCE
Alex	Austin	Male	15/07/1995	

ADDRESS
14, Kooxxxxx Crescent, NSW 2000, Australia

POSTCODE

MOBILE
+61 412 345 678

TESTS REQUESTED
X-ray needed for xxxxxxxxxx xxxxx xxxxxx

CLINICAL NOTES

X X X X X X X X X X X X

REQUESTING DOCTOR (PROVIDER NUMBER, SURNAME, INITIALS, ADDRESS)

Dr W. R.
Provider No. XXXXXXXXXXX

DOCTOR'S SIGNATURE AND REQUEST DATE

14/08/2025

Signature

LABORATORY USE ONLY	SPECIMEN COLLECTED	SPECIMENS RECEIVED	LLC
Date: Time:	Collector	Rec.by	

Notes to the Patient:

This form is valid for use with any service provider in Australia. Please make arrangements to forward the results to your usual General Practitioner.

Notes to the Provider:

We are an online tele-health service provider. Please forward the results/reports to the patient' s usual General Practitioner along with a copy to us. Our health link id is **holahlth** and fax number is **08 6365 5184.**

MEDICARE ASSIGNMENT(Section 20A of the Health Insurance Act 1973) *I offer to assign my right to benefits to the approved radiology practitioner ("APP") who will render the required radiology services and any eligible radiologist determinable service(s) established as necessary by the practitioner.In the event that I am issued with an account for those services, I also authorize that APP to submit my unpaid account to Medicare so that Medicare can assess my claim and issue me a cheque payable to the APP for the Medicare Benefit.*

Privacy note:
The information provided will be used to assess any Medicare benefit payable for the services rendered and to facilitate the proper administrator of the government health programs and may be used to update enrollment records.Its collection is authorized by provisions of the Health insurance act 1973.The information may be disclosed to the Department of Health and Ageing or to a person in the medical practice associated with this claim, or as authorized/required by law