Euflexxa Request Form

For Appointments
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Fax 07 5636 0188
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Ground Floor, 22 Frazer Street
Southport QLD 4215

Cancer Radiology and Therapy

Patient Name: ____________________ DOB: __________

Address: ____________________ Ph (H): __________

____________________ Ph (M): __________

Medicare: __________ Veteran Affairs: __________

Diabetes: NO / IDDM / NIDDM

EXAMINATION REQUEST

- ☐ Right
- ☐ Left

- ☐ Shoulder
- ☐ Hip
- ☐ Knee
- ☐ Foot
- ☐ Hand
- ☐ Other

- ☐ Euflexxa Work Up
  - ☐ NucMed Bone Scan
  - ☐ Diagnostic CT
  - ☐ Ultrasound

- ☐ 1st Injection
- ☐ 2nd Injection
- ☐ 3rd Injection

REASON FOR REFERRAL / CLINICAL NOTES

- ☐ Osteoarthritis
- ☐ Other

Doctor: __________ Signature: __________

Address: __________ Provider No: __________

Phone: __________ Copy Report: __________

Fax: __________ Date: __________