



REFERRAL FORM FOR MULTIPLE SCLEROSIS SOCIETY OF TASMANIA SERVICES

Phone: HOBART: 03 6220 1111 Fax: 03 6224 4222

Phone: LAUNCESTON: 6343 1240 Fax: 03 6344 2054

Email: aboutus@mstas.org.au

Name:
DOB:
Female / Male (circle)
Address:
Phone:
OR Patient Label

Date of Referral: For office use only: Form Received Date:

Name of Referrer: Signature
Name of organisation: Address
Phone: Email

GP: Name: (if required) Phone:

Specialist: Name: (if required) Phone:

Which service of the MS Society of Tasmania is required: (Please tick)
Counselling
Case Management
Nursing

Reason for Referral:
Referral is: Urgent Yes 24-48hrs / Non urgent Yes up to 7 days / Routine Yes up to 14 days

CONSENT:
Print Name: Address:

I (signature) give consent for referral to the MS Society of Tasmania. I agree to the release and sharing of appropriate information pertaining to this referral. I consent to my de-identified information being used for statistical and research purposes.

OR (if unable to sign)

Verbal consent has been obtained for referral to the MS Society of Tasmania.

Print Name: Signature: Relationship: