

Professor Peter Gates
Neurologist

Please email or fax all requests so appropriate time can be allocated for the test

Patient Name:

Best Contact Telephone No:

Home:

Work:

Mobile:

Date of Birth:

Referring Doctor:

Signature:

Copy to:

Patient Information:

Clean, warm, dry hands, please remove jewellery

Payment required on the day. Credit Cards, Cash or Cheque

Indication:

Carpal tunnel syndrome Ulnar nerve lesion

Other Please Specify:

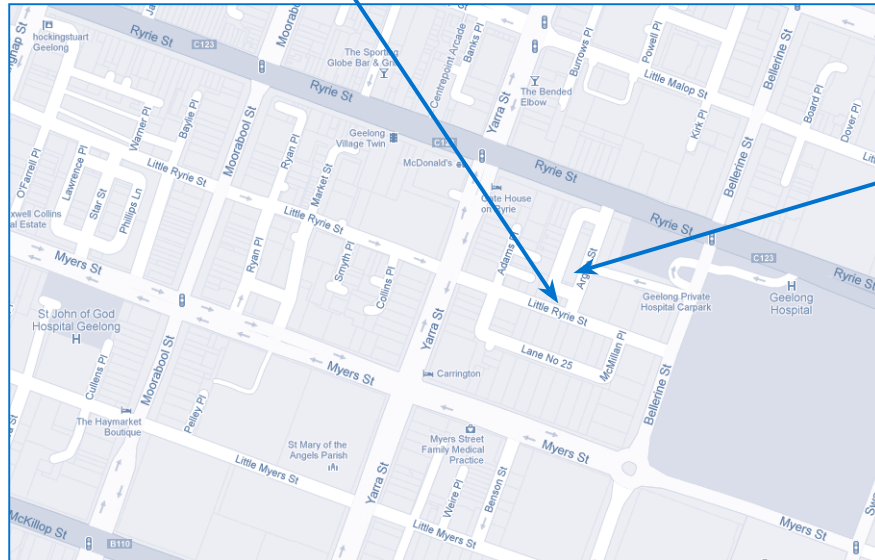
Clinical Notes:

Appointment

Date:

Time:

73 Little Ryrie Street Geelong



Underground parking