

# *Professor Peter Gates*

**Please fax referral and we will contact the patient for an appointment**

**Telephone: (03) 52261675 Facsimile: (03) 52261677**

**See Over for Map**

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**Patients Name:**

**Date of Birth:**

**Address:**

**Telephone: Mobile:**

**Home/Work:**

**Clinical Indication: Carpal Tunnel Ulnar Nerve Polymyositis**

**Peripheral neuropathy MND**

**Radiculopathy**

**Upper Limb**

**Radiculopathy Lower Limb**

**Other Specify:**

**Clinical Notes:**

**Doctors Name:**

**Signature:**

**Date:**

**Instructions:**

**Please remove watches and bracelets**

**RINGS do not need to be removed**

**Warm dry hands and NO skin lotions please**

**Suite 5, Level 3**

**Geelong Private Hospital Consulting suites**

**73 Lt Ryrie Street, Geelong , Victoria 3220**

