independence AUSTRALIA

INCONTINENT PAD SCHEME (IPS) MEDICAL REVIEWFORM *

Patient Given Name:	Patient Family Name:	
Patient Address:		
	State:	P/Code:
Date of Birth: / / Age: Months:	Permanent Resident at Home ☐ Yes ☐ No	
Clinician Name:	Clinician Phone: ( )	
Clinician Type (please circle): General Practitioner/ Medical Specialist/ Continence Nurse/ Allied Health		
Clinician Email:		
Clinician Address:		
State:	P/Code:	
Clinical Diagnosis:		
Severity of Incontinence:		
Type of Incontinence:		
Date of Last Assessment:		

Signature:

_____ **Date:** _____

*** The Medical Review Form must be completed by a registered Australian medical or allied health practitioner**

Please send the complete Medical Review Form to Independence Australia: Replied Paid 9910 Melbourne VIC 8060
Fax: 1300 788 811 or Email: customerservice@independenceaustralia.com