Suite 44, 101 Wickham Tce, Spring Hill Q 4000
Ph: 3839 1777 Fx: 3053 8124
mail@drcarey.com.au

REFERRAL FOR METABOLIC ASSESSMENT

Patient: ______________________________ DOB: _______________

Address: ____

Phone: _________________________ Medicare #: _______________

Which investigations are required?

All assessments are bulk billed unless otherwise stated.

___ **Resting Metabolic Rate**
(Indirect calorimetry test to assess baseline energy expenditure)

___ **Body Composition**
(CT Scan for assessment of visceral & subcutaneous fat)

___ **Cardiovascular & Fitness Assessment**
(Exercise Stress Test and/or Ankle Brachial Index)

These are assessment services only. Fees apply for a full endocrine consult with Dr David Carey.

Comments:

REFERRING DR DETAILS:

Signature:______________________________ **Date:**_______________

FAX / EMAIL REFERRAL TO: HEALTH+ DIABETES CENTRE
Fax: 3053 8124 Email: mail@drcarey.com.au

Endocrinologist:	Dr David Carey 058365KX
Dietitian:	Suzanna Greenwood 5106992J
Exercise Phys:	Steve Nichols 4510842Y