



MICRODIVE
TRAINING PROGRAMME
MEDICAL REFERRAL FORM

You have ticked YES to one or more of the conditions listed on the personal medical questionnaire and been asked to seek professional medical advice prior to participating in underwater activities. Please take this form along with your completed personal medical questionnaire to your own or an alternative physician for assistance.

NOTE TO PHYSICIAN

This individual wishes to participate in underwater activities while using open circuit scuba equipment but has confirmed that he or she has suffered or currently suffers from one or more conditions listed on the personal medical questionnaire which may or may not be critical to their safety underwater.

Please review the results of the personal medical questionnaire and provide your opinion on this person's suitability for participating underwater activities as above.

PERSONAL INFORMATION

FULL NAME _____	SEX _____	AGE _____
ADDRESS _____	D.O.B _____	
_____	TEL No. _____	
_____	FAX No. _____	
_____	E-Mail _____	

FAMILY PHYSICIAN DETAILS

FULL NAME _____	FACILITY NAME _____
ADDRESS _____	TEL No. _____
_____	FAX No. _____
_____	E-Mail _____

RECENT MEDICAL HISTORY

RECENT EXAMINATIONS / DATE

RECEIVING PHYSICIAN'S STATEMENT

I have referred to guidelines for conducting physical examinations for recreational scuba divers.

I am unable to identify any current conditions, which I feel should preclude this individual from scuba diving activities.

I cannot recommend that this individual participate in scuba diving activities at present.

PHYSICIANS NAME (PRINT) _____	DATE _____
PHYSICIANS NAME (SIGNED) _____	DATE _____
CLINIC NAME _____ CITY _____	COUNTRY _____
TEL No, _____ FAX No. _____	E-Mail _____