

KNEE CPM REFERRAL FORM

Email or post this completed form to Medi-Rent and a member of our team will contact you to complete your order.
 info@medirent.com.au



1. PATIENT DETAILS

Patient Name

Patient Address

Contact Number

Email

DOB

2. ORDER DETAILS

Required delivery date

Surgery date

Surgeon

Hospital

Deliver to:

Hospital

Patient Address

3. BILLING INFORMATION

Who is paying?

Patient Funded

DVA Card no.

Workcover Claim no.

Provider

4. REQUIRED DEVICE

Device (Joint) Required:

Knee

*Unless a different value is entered below, the CPM will be delivered with the maximum range.

Joint	Movement	Range Available	ROM required
Knee	Extension/Flexion	-10 – 120°	



PH: 1300 726 666

SHOULDER/ELBOW CPM REFERRAL FORM

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1. PATIENT DETAILS

Patient Name

Patient Address

Contact Number

Email

DOB

2. ORDER DETAILS

Required delivery date

Surgery date

Surgeon

Hospital

Deliver to:

Hospital

Patient Address / Home set-up
*Sydney only; charges apply.

*Instructional only. Medi-Rent staff
will not place the patient into the device.

3. BILLING INFORMATION

Who is paying?

Patient Funded DVA Card no. _____

Workcover Claim no. _____ Provider _____

4. REQUIRED DEVICE

**** PLEASE NOTE THAT DESIRED ROM VALUES
MUST BE PROVIDED FOR ALL HOME SET-UP DEVICES. ****

Device (Joint) Required:

Shoulder Elbow

*Unless a different
value is entered
below, the CPM will
be delivered with the
maximum range.



Joint	Movement	Range Available	ROM required
Shoulder Option 1.	Flexion	30 – 175°	
Shoulder Option 2.	Abduction External Rotation	30 – 175° 0 – 90°	
Elbow	Extension/Flexion Pronation/Supination	-5° – 0° – 140° 90° – 0° – 90°	

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