

**GP Referral Form**

Date: Health fund /TAC or Work Cover details

**Name of Patient:**

Date of Birth:

Patient's Telephone Number:

Patient's Home Address:

**Name of referring GP:** GP's Provider Number

GP's Address:

GP's Phone number: GP's Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE COMPLETE ALL SECTIONS**

Top of Form

1 Type of referral:

 Inpatient admission - Fax 9889 8696

 291 assessment – Fax 9834 3666

 Consultancy and ongoing care – Fax 9834 3666

 Day Program - Fax 9805 7395

Bottom of Form

2 Diagnosis:

Please complete[[1]](#endnote-1)

3 Current presentation:

Please complete

4 Drug & Alcohol history:

Please complete

5 Past history:

Please complete

6 Forensic history:

Please complete

7 Current medications:

Please complete

8 Medical conditions:

Please complete

1. Office use: if patient is admitted, fill out intake form [↑](#endnote-ref-1)