

HOSPITAL ADMISSION

Patient Name:	Referring GP/Psychiatrist Name
Address:	Practice Address:
Telephone:	Provider Number:
Date of Birth:	Telephone # Practice: Mobile:
Private Health Fund	FAX Number
Membership Number	Email Address:

REASON FOR REFERRAL TO HOSPITAL: **General** **Drug & Alcohol**

Please provide covering letter regarding patient's illness and previous medical history.

In last 7 days, has this patient been at: **Delmont Private**

Other Private Hospital

Not Applicable

Delmont Private does not admit patients directly to the Drug & Alcohol Program. An assessment is required by a Delmont Addiction Medicine Specialist prior to admittance.

Referring Dr Signature	Date
Print Name	Mobile number

PLEASE FAX FORM to: 9889 8696

For enquiries contact Intake Clinician: 9805 7390