

GP Referral Form

Date: Health fund details:

Name of Patient:

Date of birth:

Patient Telephone Number:

Name of referring GP: GP Provider Number

Address of Practice:

Phone number: Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 9889 8696

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

9 WorkCover/TAC applicable

Please complete

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