

OUTPATIENT MEDICAL REFERRAL

This service is for doctors who are requesting information, advice, and management of their patients' alcohol and other drug issues.

<u>REFERRING DOCTOR</u>	<u>PATIENT</u>
NAME: _____ _____	FIRST NAME: _____ SURNAME: _____
ADDRESS: _____ _____ _____	DATE OF BIRTH: ____ / ____ / ____ MALE / FEMALE ADDRESS: _____ _____
PHONE: _____ FAX: _____	PHONE: _____ MOBILE: _____
PROVIDER NUMBER (*required) _____ (or stamp if preferred)	MEDICARE NUMBER: □□□□□□□□□□ Ref No <input type="checkbox"/> EXPIRY DATE: _____
Has the client previously been seen by this service? YES <input type="checkbox"/> NO <input type="checkbox"/> Year _____	HEALTHCARE CARD NUMBER: □□□□□□□□□□ EXPIRY DATE: _____

THE TURNING POINT MEDICAL SERVICE I AM REFERRING THE PATIENT TO:

- Specialist medical assessment of substance use disorders
- Specialist alcohol assessment
- Specialist opioid pharmacotherapy service
- Addiction specialist assessment of substance use disorders and co-morbid persisting pain

REASON FOR REFERRAL: _____

HISTORY OF OTHER ALCOHOL & DRUG USE (Current drug(s) used, amount, frequency, treatment history):

MEDICAL HISTORY: _____

MEDICATION:

MEDICATION	DOSE	PICKUP FREQUENCY (if applicable)

Allergies: _____

HISTORY OF MENTAL HEALTH ISSUES OR ACQUIRED BRAIN INJURY

OTHER RELEVANT SOCIAL OR FORENSIC ISSUES:

Further information or copies of relevant documentation may be attached and forwarded with this referral.

Signature of referring doctor: _____ Date: ____ / ____ / ____

Please return completed referral form to:

Fax: (03) 8413 8499
 Phone: (03) 8413 8413