Please complete the following referral tool and return to our Intake Team. An Assessing Officer will contact you to proceed with the next step.

Phone: (02) 9905 3667 Fax: (02) 9466 6470
Email: info@southpacificprivate.com.au

SOUTH PACIFIC PRIVATE
Australia's Leading Treatment Centre

www.southpacificprivate.com.au

South Pacific Private
Medical Referral Form

Provider No: _____ Date: _____

Patient Surname: _____ Given Name: _____

Gender: _____ Date of Birth: _____

Patient Phone No: _____

Patient Allergies: _____

Recorded Height: _____ Recorded Weight: _____ BMI: _____

Clinical History: _____

_____

_____

Reason for Referral: _____

_____

_____

Have they previously attended South Pacific Private?..... Yes ☐ No ☐

Have they been admitted to any hospital in the last 12 months? ..... Yes ☐ No ☐

- If yes, was it within the last 28 days?..... Yes ☐ No ☐
- If yes, please name the facility(s) _____

Do you plan to continue to treat this person post discharge?.....Yes ☐ No ☐

Comments: _____

_____

Referral Form

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Medications:

Date	Medication & Dose

Please tick as appropriate:

☐ **Suicide/self harm risk** ..... Yes ○ No ○

Please provide details: _____

_____

☐ **Aggression/violence risk** ..... Yes ○ No ○

Please provide details: _____

_____

☐ **Medical Conditions (including open wounds or pressure sores)** ..... Yes ○ No ○

Please provide details: _____

_____

☐ **Mobility Concerns** ..... Yes ○ No ○

Please provide details: _____

_____

Referral completed by: (PLEASE PRINT IN BLOCK LETTERS)

Name: _____ Date: _____

Organisation: _____ Qualification: _____

Phone: _____ Fax: _____ Email: _____

Postal Address: _____

Signature: _____ Provider Number: _____

Referral Form