

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

Phone: (02) 9905 3667 Fax: (02) 9971 7208

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SOUTH PACIFIC PRIVATE

Australia's Leading Treatment Centre

Doctor Referral Form

Referral completed by: (PLEASE PRINT IN BLOCK LETTERS) _____ Date: _____

Doctor Provider No.: _____ **Name:** _____

Organisation: _____

Email: _____

Postal Address: _____

Phone: _____ **Fax:** _____

Signature: _____

Patient Surname: _____ **Given Name:** _____

Gender: _____ **Date of Birth:** _____

Patient Phone No: _____

Patient Allergies: _____

Recorded Height: _____ **Recorded Weight:** _____ **BMI:** _____

Clinical History: _____

Reason for Referral: _____

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

Have they been admitted to any hospital or AOD rehabilitation facility 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: _____

Medications:

Date	Medication & Dose

Please tick as appropriate:

Suicide/self harm riskYes No

Please provide details: _____

Aggression/violence riskYes No

Please provide details: _____

Medical Conditions (including open wounds or pressure sores)Yes No

Please provide details: _____

Mobility ConcernsYes No

Please provide details: _____

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