

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) 9971 7208
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: _____

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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