

Doctor's Referral Form

Please complete the following referral form and return to our Intake Team. A Case Manager will contact you to proceed with the next step.

Phone: (02) 9905 3667 Fax: (02) 9905 9696

Email: info@southpacificprivate.com.au

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

Doctor Provider No.: _____ **AHPRA Registration 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: _____

Do they have any dietary requirements due to allergies, intolerances or medical conditions?.....Yes No

- If yes, provide details _____

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 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: _____

Memory or Cognition Concerns (while not intoxicated)..... Yes No

Please provide details: _____
