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) 9466 6470

Email: info@southpacificprivate.com.au

SOUTH PACIFIC PRIVATE

Australia's Leading Treatment Centre

Doctor's 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: _____

_____

_____

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: _____

_____