

TURNING POINT ALCOHOL & DRUG CENTRE

Clinical Services
54-62 Gertrude Street
Fitzroy VIC 3065

T 03 8413 8444
F 03 9486 9766



OUTPATIENT REFERRAL

This service is for patients who are requesting information, advice, and management of their alcohol and drug issues. We provide the following services and programs at Turning Point:

1. Individual and group counselling
2. Consultation by an Addiction Medicine Specialist – for assessment, advice or management of substance dependence
3. Specialist interventions for methamphetamine users
4. Acquired Brain Injury (ABI) consultation
5. Outreach services – including a Home Based Withdrawal service
6. Forensic client service
7. Mental health interventions

<u>REFERRING DOCTOR</u>	<u>PATIENT</u>
NAME: _____	FIRST NAME: _____
ADDRESS: _____ _____	SURNAME: _____
PHONE: _____	DATE OF BIRTH: ____ / ____ / ____
FAX: _____	MALE / FEMALE
PROVIDER NUMBER: _____	ADDRESS: _____ _____
(or stamp if preferred)	PHONE: _____ MOBILE: _____
Has the client previously been seen by this service? YES <input type="checkbox"/> NO <input type="checkbox"/> Year _____	MEDICARE NUMBER: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ref No <input type="checkbox"/>
	EXPIRY DATE: _____
	HEALTHCARE CARD NUMBER: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	EXPIRY DATE: _____

THE TURNING POINT SERVICE I AM REFERRING THE PATIENT TO:

- Individual counselling
- Group program
- Consultation by an Addiction Medicine Specialist
- Specialist interventions for methamphetamine users
- Acquired Brain Injury (ABI) consultation
- Outreach support
- Home Based Withdrawal
- Forensic client service
- Mental health interventions

REASON FOR REFERRAL: _____

HISTORY OF OTHER ALCOHOL & DRUG USE: _____

IS THE PATIENT CURRENTLY RECEIVING ALCOHOL AND DRUG TREATMENT?
yes/no specify _____

MEDICAL HISTORY: _____

MEDICATION:

MEDICATION	DOSE	PICKUP FREQUENCY (if applicable)

Allergies: _____

HISTORY OF MENTAL HEALTH ISSUES (including acquired brain injury):

OTHER RELEVANT SOCIAL ISSUES:

- Homelessness / inappropriate housing
- Isolation – difficulty accessing services, poor supports
- Financial difficulties
- Forensic issues
- Other legal problems (e.g. civil cases)

(Please provide relevant details): _____

Further information or copies of relevant documentation may be attached and forwarded with this referral.

Signature of referring doctor: _____ Date: ____ / ____ / ____

Please return completed referral form by:

fax (03 9486 9766) or post (54-62 Gertrude St, Fitzroy VIC 3065)