OUTPATIENT MEDICAL REFERRAL

This service is for doctors who are requesting information, advice, and management of their patients' alcohol and other drug issues.

REFERRING DOCTOR	**PATIENT**
NAME: ______________________________	FIRST NAME:______________________________
	SURNAME: ______________________________
ADDRESS: ______________________________	DATE OF BIRTH: _____ / _____ / ______
______________________________	MALE / FEMALE
______________________________	ADDRESS: ______________________________
	______________________________
PHONE: ____________________	PHONE: ____________ MOBILE: ______________
FAX: ____________________	MEDICARE NUMBER: ☐☐☐☐☐☐☐☐☐☐ Ref No ☐
PROVIDER NUMBER (**required*) ____________________	EXPIRY DATE: _____________
(or stamp if preferred)	HEALTHCARE CARD NUMBER: ☐☐☐☐☐☐☐☐☐☐
Has the client previously been seen by this service? YES ☐ NO ☐ Year __________	EXPIRY DATE:__________

THE TURNING POINT MEDICAL SERVICE I AM REFERRING THE PATIENT TO:

- ☐ Specialist medical assessment of substance use disorders
- ☐ Specialist alcohol assessment
- ☐ Specialist opioid pharmacotherapy service
- ☐ Addiction specialist assessment of substance use disorders and co-morbid persisting pain

REASON FOR REFERRAL: ____
____
____
____

HISTORY OF OTHER ALCOHOL & DRUG USE (Current drug(s) used, amount, frequency, treatment history):
____
____
____
____

MEDICAL HISTORY:____
____
____
____

MEDICATION:

MEDICATION	DOSE	PICKUP FREQUENCY (if applicable)

Allergies: ____

HISTORY OF MENTAL HEALTH ISSUES OR ACQUIRED BRAIN INJURY
____
____
____
____

OTHER RELEVANT SOCIAL OR FORENSIC ISSUES:
____
____
____
____

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 to:
Fax 03 9416 3420
Phone 03 8413 8413