

Fresh Start Recovery Programme

Referral Form



Fresh Start
Recovery Programme

Referring Doctor (Use Stamp if Preferred)

Name:.....
 Address:.....

 Phone:.....
 Fax:.....
 Provider Number:.....

Has the client previously been seen by this service?
 Yes No Year:.....

Patient

First Name:.....
 Surname:.....
 Date of Birth/...../.....
 Male/Female Language Spoken:.....
 Address:.....

 Phone:..... Mobile:.....
 Medicare number and Expiry Date:
 Ref No
 Expiry Date:
 Health Care Card

Reason for Referral:

.....

Patient Medical History: (Attach separate sheet if necessary)

.....

BBV: Immunised Hepatitis A Hepatitis B *Please attach most recent HIV/HCV/HAV/HBV/LFT tests.*

Patient Psychiatric History: (Attach separate sheet if necessary)

.....

Has a Mental Health Care Plan been completed? Yes No Date:...../...../..... Dr:.....

Current Medications: (Attach separate sheet if necessary)

Medication	Dosage	Medication	Dosage

Allergies:.....

Substances Used (please tick)

- Alcohol Amphetamines Opiates Cannabis Benzodiazepines
 Suboxone/Subutex Methadone Tobacco Other (please list below)

Other Relevant Information:

Referrers Signature: Date:.....