## OUTPATIENT MEDICAL REFERRAL

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

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

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

- ☐ Specialist medical assessment of substance use disorders
- ☐ Specialist alcohol assessment
- ☐ Specialist mental health and substance use assessment (Addiction Psychiatry Item 291)
- ☐ 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