Fresh Start Recovery Programme

Referral Form

Fresh Start
Recovery Programme
Helping Families with Addictions

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:

.....

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Patient Medical History: (Attach separate sheet if necessary)

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

Patient Psychiatric History: (Attach separate sheet if necessary)

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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)

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Other Relevant Information:

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Referrers Signature: ..... **Date:**.....

Send this form to the Clinical Coordinator, Subiaco **Fax** (08) 9388 7073 **Tel** (08) 9381 1333 **Email** info@freshstart.org.au