Western Health

DRUG HEALTH SERVICES REFERRAL FORM

Adult & Specialist Services
3-7 Eleanor Street
Footscray Vic 3011
Ph. (03) 8345 6682
Fax.(03) 8345 6027

Adolescent Community Programs
49 Nicholson Street
Footscray Vic 3011
Ph. (03) 9689 5533
Fax.(03) 9687 2749

ATTACH BRADMA HERE

WHDHS18

REFERRAL FORM

Clients / Patient Details

Title: Given Name: Surname:

Previous Family Name: Alias:

Sex: ☐ Male ☐ Female Date of Birth:

Residential Address:

Suburb: Postcode: Telephone: Mobile:

Country of Birth: Preferred Language: Interpreter Required: ☐ Yes ☐ No ☐ Not Stated

Indigenous Status: ☐ Not Aboriginal or Torres Strait Islander ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal or Torres Strait Islander

Next of Kin Name: Phone:

Relationship to Client:

Referrer Details

Name: Position: Agency:

Address: Phone: Fax:

❑ Please tick if this referral is for Addiction Medicine Specialist Review

Requested Specialist Name _____

Medicare Australia Provider No._____

(Medical Practitioners Only)

Reason for Referral and desired outcome (if known)

Other Services Involved (please include GP)

Name: Position: Agency:

Address Telephone:

Name: Position: Agency

Address Telephone:

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REFERRAL FORM

Background Information

Drug and Alcohol:

Medical History:

Allergies / Alerts:

Mental Health History & Current Mental Health Issues:

Current Medications:

Referral Completed by:

Name: Signature: Date:

Please fax referral to : Adult and Specialist Services (03) 8345 6027 or
Adolescent Community Programs (03) 9687 2749

Assessment Details (to be completed by Drug Health Services Assessment and Intake Clinician)

Date: Time: Location: