



PATIENT DETAILS

Name:
Date of birth:
Address:
Phone:
Medicare number: Expiry:

HEALTHCARE PROFESSIONAL DETAILS

Name:
GP
NP
Other:
Address:
Phone:
Email address:

NATURE OF CONSULTATION

- LAIB
Minimal Supervision Regime
Secondary consult

PRIMARY DRUG/S OF CONCERN

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SECONDARY DRUG/S OF CONCERN (IF APPLICABLE)

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REASON FOR REFERRAL

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CURRENT MEDICATIONS

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PATIENT MEDICAL HISTORY

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PATIENT MENTAL HEALTH HISTORY

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