PATIENT REFERRAL FORM

ramps
Rural Addiction Medicine + Pharmacotherapy Specialists

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
- ☐ Shared care

PRIMARY DRUG/S OF CONCERN

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SECONDARY DRUG/S OF CONCERN *(IF APPLICABLE)*

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REASON FOR REFERRAL

CURRENT MEDICATIONS

PATIENT MEDICAL HISTORY

PATIENT MEDICAL HISTORY *(CONTINUED)*

PATIENT MENTAL HEALTH HISTORY