

**GP/PSYCHIATRIST REFERRAL**

**FOR HOSPITAL ADMISSION**

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| **Patient Name:** | |
| Address: | |
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| Telephone: | Date of Birth: |
| Private Health Fund: | Membership Number: |
| **Reason for Referral to Hospital:**  Mental Health Diagnosis  Substance Use & Abuse  (DPH does not admit patients directly to the SUAP Program. An assessment is required by a Delmont Addiction Medicine Specialist prior to admittance)  ***Please provide a covering letter regarding the patient’s illness and previous medical history*** | |
| In the last 14 days, has the patient been admitted to:  Delmont Private Hospital  Other Hospital – specify:  Not admitted to any hospital | |
| **Referring GP/Psychiatrist Name:** | |
| Provider Number: | |
| Practice Address: | |
|  | |
| Practice Telephone: | Mobile: |
| Fax Number: | Email Address: |
| Dr Signature: | Date: |
| **PLEASE FAX FORM TO: 9889 8696** | |
| *For enquires contact the Intake Coordinator – ph 9805 3390* | |