

**GP/PSYCHIATRIST REFERRAL**

**FOR HOSPITAL ADMISSION**

|  |
| --- |
| **Patient Name:** |
| Address: |
|  |
| 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* |