MALVERN
PRIVATE HOSPITAL
*Australia's Leading Addiction Treatment Centre*

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# Inpatient Care Referral Form:

| | | |
|---|---|---|
| Date of Consultation | Referring Dr:<br><br>Contact Number:<br><br>Provider Number: | Practice Address:<br><br>Contact Number:<br><br>Fax/email: |
| Patient Name: | Patient DOB: | Patients' Contact Number: |
| Patients Address:<br><br>Carers' details and emergency contact number | Medicare Number:<br><br>Health Insurance Details:<br><br>Provider Name:<br><br>Membership No: | WorkCover details if applicable (please note: work cover approval for hospital in-patient admissions must be in writing prior to the patient admission) |
| Addiction Issues – Substance and Behaviour Addictions: | | |
| Current Prescribed Medications: | | |
| Past History: Relevant biological, Psychological and Social history | | |
| Risk and Co-morbidities: note any associated risks and co-morbidities including suicidal tendencies/ self-harm and risks to others | | |
| Patients' Needs/Goals: | | |
| Is the Patient Physically stable? Yes - No<br>If Not what Actions/Treatment needs to be implemented? | | |
| Patient Signature & Date: | Referring Drs' Signature & Provider Number Date: | |