ST JOHN OF GOD HEALTH CARE

Community Practitioner Referral Form

St John of God Hospital
13 Grantham Street
Burwood NSW 2134
Tel: 61 2 9715 9200
Fax: 61 2 9747 5223
Admissions Fax: 61 2 9715 9292
www.sjog.org.au

St John of God Hospital
177 Grose Vale Road
North Richmond NSW 2754
Tel: 61 2 4570 6100
Fax: 61 2 4571 1552
Admissions Fax: 61 2 4571 3561
www.sjog.org.au

Referring Practitioner

Name:					
Provider Number		Phone Number		Fax	
Practice address					

Patient

Name:		Phone Number:	
Date of Birth	/ /	☐ Male	☐ Female
Address			

Health Fund: …… **Membership No:** ……

Interpreter required: …… **DVA Number:** ……

Preferred language is: …… **Insurance:** ……**Claim No**:……

Pension Card Number: …… **Medicare Number:** ……

Patient already known to St John of God? (circle response) Yes / No

Reason for referral

Psychiatric history/ duration/ treatment (previous counselling/ ECT/ etc)

Alerts (☑relevant items) ☐No Alerts ☐Suicide - Risk ☐Self harm ☐Substance abuse ☐Falls risk
☐Drug reaction ☐Cognitive impairment ☐Aggression ☐Other (specify) _____

Doctor's Signature…… ***Date:*** ……

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Patient

Social history (include other current services)
Medical history
Investigation/ Test results
Current medications (or attached a print out) *Allergies:*
Any other comments
Consent to referral and sharing of relevant information (please circle): YES / NO Attach 'Patient Consent Form' if restrictions apply.
Doctor's signature …….. ***Date:*** ……..

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