Please complete the following referral tool and return to our Intake Team. An Assessing Officer will contact you to proceed with the next step.

Phone: (03) 9533 7888
Email: referrals@arrowhealth.com.au

arrow health

Referral Form

Referral completed by: (PLEASE PRINT IN BLOCK LETTERS) Date: _____

Doctor Provider No.: _____ Name: _____

Organisation: _____

Email: _____

Postal Address: _____

Phone: _____ Fax: _____

Signature: _____

Patient Surname: _____ Given Name: _____

Gender: _____ Date of Birth: _____

Patient Phone No: _____

Patient Allergies: _____

Clinical History: _____

_____

_____

Reason for Referral: _____

_____

_____

_____

Have they previously attended Arrow Health?.....Yes ☐ No ☐

Have they been admitted to any hospital or AOD rehabilitation facility in the last 12 months? Yes ☐ No ☐

- If yes, was it within the last 28 days?..... Yes ☐ No ☐
- If yes, please name the facility(s)_____

Do you plan to continue to treat this person post discharge?..... Yes ☐ No ☐

Comments:_ _____

_____

_____

Medications:

Date	Medication and Dose

Please tick as appropriate

☐ **Suicide/self harm risk** .....Yes ☐ No ☐
Please provide details:_ _____

_____

☐ **Aggression/violence risk** .....Yes ☐ No ☐
Please provide details:_ _____

_____

☐ **Mental Health History**.....Yes ☐ No ☐
Please provide details:_ _____

_____

☐ **Mobility Concerns** .....Yes ☐ No ☐
Please provide details:_ _____

_____

☐ **Medical Conditions (including open wounds or pressure sores)** ....Yes ☐ No ☐
Please provide details:_ _____

_____