Please complete and return to our Intake & Assessment Team. One of the team will contact you within 24 hours to proceed with the next step.

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

Referral Form

*This form can be filled out online. Click on a field and fill in the relevant information.

Referral completed by: (PLEASE PRINT IN BLOCK LETTERS)

Date: ______________________

Doctor Provider No.: ______________________ Name: ______________________

Organisation: ______________________

Email: ______________________

Postal Address: ______________________

Phone: ______________________ Fax: ______________________

Signature: ______________________

Client Information

Surname: ______________________ **Given Name:** ______________________

Gender: ______________________ **Date of Birth:** ______________________

Ph: ______________________

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/ies:** ____

____

____

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

Comments:_ ____

____

____

Medications:

Date	Medication and Dose

Please tick as appropriate and attach additional notes if required:

☐ **Suicide/self harm risk.** Please provide details: ____

____

☐ **Aggression/violence risk.** Please provide details: ____

____

☐ **Mental Health History.** Please provide details: ____

____

☐ **Mobility Concerns.** Please provide details: ____

____

☐ **Medical Conditions (including open wounds)**
Please provide details:_ ____

____