REFERRAL FORM

CONFIDENTIAL INFORMATION
Fax To: 07 3298 6200
Email To: wellness@thebanyans.com.au
Your referral and assessment report MUST be attached

Patient Details Patient Name:	**Referring Doctor Details** Doctor Name:
Date of Birth:	Speciality:
Phone:	Phone:
Mobile:	Fax:
Address:	Address:
Email:	Email:

Medicare No:	Ref No	Exp Date:	DVA or Private Health Fund:	Member No:

PRESENTING SYMPTOMS

MEDICAL HISTORY (including allergies):

PSYCHIATRIC HISTORY

PROVISIONAL DIAGNOSIS

MEDICATION (current medications and doses, previous medications tried):

ALCOHOL, SMOKING, AND SUBSTANCE MISUSE HISTORY