



Queensland Government

(Office use only - affix patient identification label here)

Metro North Health – Alcohol and Drug Service

GP Referral

GP REFERRAL

Please provide a health summary, collated from GP practice software, including the below items:

- Name and demographics including address, phone, Medicare
- Current medications
- Allergies
- Active medical history and relevant past medical history
- Investigations/results relevant to the referral
- GP (referrer) details including name, address, phone, fax and provider number

In addition, please answer the following three questions.

1. What is the substance/s of concern?

Blank space for answer to question 1.

2. What do you (the GP) believe the problem is?

Blank space for answer to question 2.

3. I am referring this patient for:

- Withdrawal Management (detox)
- Opioid Replacement Therapy
- Opinion from a Medical Addiction Specialist
- Opinion on Schedule 8 medication
- Management of Schedule 8 medication

(If selecting one of the first five options, if applicable, please name below the Medical Addiction Specialist from whom you are requesting the opinion or management – named referral)

Name of requested specialist:

- Counselling / psychological support
- Assess for other suitable treatment options e.g. residential rehabilitation
- Other: _____

GP Signature:

Date:

Fax both the health summary and this referral form to:

(07) 3837 5914

DO NOT WRITE IN THIS BINDING MARGIN