Peninsula Health

OPIOID PHARMACOTHERAPY SERVICE REFERRAL

UR NUMBER .....

SURNAME .....

GIVEN NAMES .....

DATE OF BIRTH .....

Please fill in if no Patient Label available

App.12/8/2024 Print Code:18557

PHF3511198?

Peninsula UR *(if internal referral)*: ..... D.O.B: ..... Age: .....

Surname: ..... Given Name: .....

Address: .....

Aboriginal / Torres Strait Islander: .....

Current Opioid Pharmacotherapy Treatment Type *(e.g. Methadone, Suboxone, Sublocade, Buvidal)*: .....

.....

Dose: ..... Script Expiry Date: .....

If Sublocade/Buvidal, date of last administration: .....

Due date for next Sublocade/Buvidal dose: .....

Current prescriber: .....

Dispensing pharmacy: .....

Reason for Referral: .....

Other Prescribed Medications: .....

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Any other substance use reported *(type, frequency)*: .....

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Medical History: *Attach any relevant investigations, cognitive screens, LFT's, discharge summaries if available* .....

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..... HCV status: .....

Mental Health Diagnosis & History: .....

.....

Psychosocial Summary *(note any issues with housing, FV, or employment that may impact treatment)*: .....

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Referrer Details

Name: ..... Organisation & Position: .....

Contact details: .....

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Fax referral to 9125 9846

OPIOID PHARMACOTHERAPY SERVICE REFERRAL

MR/351198

12/8/2024 Print Code:18557 Ref.