GP Liaison Referral Form

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| REFERRER NAME AND ROLE: | |
| DATE AND TIME: | |
| GP PRACTISE: | |
| NAME OF PATIENT: | |
| PATIENT CONTACT DETAILS: | |
| DOB: | GENDER: |
| MEDICAL HEALTH INFORMATION: | |
| SUBSTANCE USE INFORMATION: | |
| PATIENT AIMS AND GOALS: | |
| PATIENT SUPPORT NETWORK (FRIENDS/FAMILY/PROFESSIONAL SUPPORT): | |

Email to: [changing.habits@changinglives.cjsm.net](mailto:changing.habits@changinglives.cjsm.net)