

Patient Referral Form

Refer a patient to Chronic Doctors for assessment and ongoing care.

07 3180 3901
hello@chronicdoctors.com.au

Referring Practitioner Details

Practitioner Name

Provider Number

Clinic / Practice Name

Practitioner Type

Phone Number

()

Email Address

Street Address

Patient Details

Full Name

Date of Birth

/ /

Phone Number

()

Email Address

Preferred Contact Method

Email Phone

Residential Address

Referral Information

Reason for Referral

- | | | |
|--|---|---|
| <input type="checkbox"/> Sleep support | <input type="checkbox"/> Stress, fatigue or burnout | <input type="checkbox"/> Nicotine cessation support |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> General chronic care support | <input type="checkbox"/> Other (please specify) |

Presenting Condition: Primary diagnosis or presenting concern

Relevant Symptoms

Duration of Condition

Has the condition been present for more than 3 months? Yes No

Previous Treatment History

Have other treatment options been trialled or deemed unsuitable? Yes No

If yes, please provide details:

Clinical Information

Additional Clinical Information: Please provide any relevant clinical information to support assessment and care planning

Supporting Documentation: Please attach any relevant supporting documentation, where available

- | | | |
|--|---|---|
| <input type="checkbox"/> Health Summary | <input type="checkbox"/> Specialist Letters | <input type="checkbox"/> Pathology Results |
| <input type="checkbox"/> Imaging Reports | <input type="checkbox"/> Medication List | <input type="checkbox"/> Other (please specify) |

I confirm that the patient has consented to this referral and the sharing of relevant health information.

I understand that Chronic Doctors may contact the patient directly regarding assessment and ongoing care.

Please email completed referral forms and any supporting documentation to hello@chronicdoctors.com.au