INTAKE 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			***Recommending Doctor Details***	
Patient Name:			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:

Assessment Details **SYMPTOMATOLOGY** & Issues of concern (summary of reason for attending):

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

DIAGNOSTIC CONSIDERATIONS ('x' each box that is applicable)

☐	AOD & substance abuse	☐	Anxiety disorders	☐	Borderline personality issues
☐	Behavioural addictions	☐	Eating disorders & related	☐	Psychotic presentations
☐	Mood disorders & depression	☐	Trauma related concerns & PTSD	☐	Schizoaffective issues
☐	Risks of self-harm	☐	Other: _____		

Allergies (please specify):

Please detail presentation/symptomology, with date of formal diagnosis if applicable.

In relation to above, please specify particulars for consideration of a Banyans treatment program.

What does the patient hope to achieve through a Banyans shorter term program?