



GP Liaison Referral Form

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):	

Referrals via:

- Phone: 01904 621776
- Post: Changing Habits, Changing Lives Oaktrees, 111 Walmgate, York, YO1 9UA