

PATIENT DETAILS		SPECIFIC REFERRAL QUESTION:	
Name <small>Surname Given Names</small>		Sex <input type="checkbox"/> M <input type="checkbox"/> F D.O.B. / /	<input type="checkbox"/> Diagnostic Clarification <input type="checkbox"/> Treatment Suggestions <input type="checkbox"/> Case Management Details (why now?): _____ _____ _____ _____ _____
Address		Phone H: _____ M: _____	
Duration as treating GP		Allergies	
Interpreter required? <input type="checkbox"/> Language: _____			
Client Consent for Referral <input type="checkbox"/> Written <input type="checkbox"/> Verbal			
Spouse <input type="checkbox"/> Y <input type="checkbox"/> N Children <input type="checkbox"/> Y <input type="checkbox"/> N How many? _____ Type of Employment _____ Hospital Psych Admissions <input type="checkbox"/> Y <input type="checkbox"/> N		What will be your role post assessment? _____ _____ _____	
Recent Events/Stressors		Drug and Alcohol	
Social Supports/Pt Strengths		Other Health Professional Involved (currently) <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Psychologist <input type="checkbox"/> Community Health <input type="checkbox"/> Other	

### PRESENTING PROBLEM

Symptoms (list): \_\_\_\_\_

Duration: \_\_\_\_\_ Previous Episodes:  Y  N

Provisional Diagnosis: \_\_\_\_\_

Current/Previous Treatments: \_\_\_\_\_

Adherence to treatments:  High  Medium  Low  Unknown

Likely adherence to recommended treatments:  High  Medium  Low  Unknown

RISK (to self or others)  Low  Medium  High (if moderate or high referral to CAT team or other emergency service)

### HISTORY

Medical:  Family:	Psychiatric:  Forensic:
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### CURRENT MEDICATION

Name	Dose	Freq	Name	Dose	Freq

YOUR DETAILS <input type="checkbox"/> GP <input type="checkbox"/> CHS <input type="checkbox"/> OTHER		Office use only REFERRAL RECEIVED BY:  Date:
Name: _____ Fax: _____ Agency/Practice: _____ Contact Times: _____ Address: _____ Phone: _____ _____ Signature: _____ Date: _____	Please Attach Health Summary and ANY ADDITIONAL INFORMATION <b>FAX TO: (03) 9076 9853</b>	