# REFERRAL FORM

## PATIENT DETAILS

**Name** Surname Given Names

**Sex** ☐M ☐F

**D.O.B.** / /

**Address**

**Phone**
**H:** _____
**M:** _____

**Duration as treating GP**

**Allergies**

**Interpreter required?** ☐
Language: _____

**Client Consent for Referral** ☐Written ☐Verbal

## SPECIFIC REFERRAL QUESTION:

☐ Diagnostic Clarification
☐ Treatment Suggestions
☐ Case Management

**Details** (why now?):

_____
_____
_____
_____
_____
_____

**Spouse** ☐Y ☐N **Children** ☐Y ☐N **How many?**_____

**Type of Employment** _____

**Hospital Psych Admissions** ☐Y ☐N

**What will be your role post assessment?**

**Recent Events/Stressors**

**Drug and Alcohol**

**Social Supports/Pt Strengths**

**Other Health Professional Involved (currently)**
☐Psychiatrist ☐Psychologist ☐Community Health ☐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:**

**Psychiatric:**

**Family:**

**Forensic:**

## CURRENT MEDICATION

| Name | Dose | Freq | Name | Dose | Freq |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**YOUR DETAILS** ☐GP ☐CHS ☐OTHER

**Name:** _____ **Fax:** _____

**Agency/Practice:** _____ **Contact Times:** _____

**Address:** _____ **Phone:** _____

_____ _____

**Signature:** _____ **Date:** _____

Office use only
**REFERRAL RECEIVED BY:**

**Date:**

Please Attach Health Summary and
ANY ADDITIONAL INFORMATION
**FAX TO: (03) 9076 4788**

**PSYCHIATRY: WAIORA CMHS**
Phone: 9076 4700 Fax: 9076 4788 (9am - 5pm Monday to Friday)

**ALFRED PSYCHIATRY**

VCS #3319 03-08