

Primary Mental Health Team

ph: (03) 9076 4775

REFERRAL FORM

for high prevalence disorders

PATIENT DETAIL

Name:..... Address:.....	D.O.B.:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
	Contact detail: H..... M.....	Interpreter required? <input type="checkbox"/> N <input type="checkbox"/> Y Language:.....
	Employment/pension/other:	Relationship status:

REFERRAL DETAIL

(Practice stamp welcome)		Reason(s) for referral :
Referrer:		<input type="checkbox"/> Diagnostic clarification
Agency/Practice:		<input type="checkbox"/> Medication advice
Address:		<input type="checkbox"/> Biopsychosocial management plan
Phone: Fax:		<input type="checkbox"/> Other:

CURRENT PRESENTATION

Presenting symptom cluster (s):
 Depression Anxiety Mania Psychosis Personality Drug & alcohol Gambling other

Detail of current presentation: (symptoms / duration/previous episodes)
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.....
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Recent psychosocial stressors: (work, family, relationships, loss etc)
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.....

Protective factors (Social supports & Patient Strengths e.g. character, family, work, relationships)
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Current/recent Medication: (name/dose/Freq)	Adherence to treatment: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> low <input type="checkbox"/> Unknown
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Other health professionals involved currently/recently Psychiatrist; Psychologist; Community health Other
(Please list name; profession; contact detail)
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Risk (to self or other):
 Low moderate high (if moderate or high consider referral to CAT team or other emergency service)

HISTORY

Medical/ Forensic/family:.....
.....
.....
.....
.....

Past psychiatric diagnosis: N Y Detail (type & date):

Contact with psychiatric services: N Y Detail (type & date/year):

CLIENT CONSENT

<ul style="list-style-type: none">Client consent for referral to the PMHT has been obtained: <input type="checkbox"/>Yes <input type="checkbox"/>NoThe client has given consent for release of information between PMHT, referrer and other professionals identified above: <input type="checkbox"/>Yes <input type="checkbox"/>No <p>Client signature:..... Date:.....</p>	<p>Please attach any additional information and relevant reports</p> <p>FAX TO: 9076 9855</p>
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OFFICE USE ONLY: Referral received by: Date: