REFERRAL FORM

IF YOU WISH TO DISCUSS REFERRAL, PLEASE CALL: 9076 4731

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

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

Type of Employment _____

Hospital Psych Admissions ☐Y ☐N

SPECIFIC REFERRAL QUESTION:

☐ Diagnostic Clarification
☐ Treatment Suggestions
☐ Case Management

Details (why now?): _____

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
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

ALFRED PSYCHIATRY COMMUNITY

VCS #3136 01-08