

☐ Alfred ☐ Sandringham ☐ Caulfield

REFERRAL TO GAMBLING MINDS

Last name*		First name*	
*mandatory fields			
<p>Statewide Mental Health and Gambling Harm Service Level 3/607 St Kilda Road, Melbourne, VIC, 3004 Enquiries: T 9076 9888 F 9076 9855 E mhghvic@alfred.org.au</p> <p>Your patient will be contacted by Gambling Minds with appointment details</p> <p>Note: Gambling Minds is not an acute service. If you require urgent assistance, contact your local mental health service</p>			
Patient details			
Date of birth*		Country of birth	
Sex at birth <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other		Gender identity <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Male <input type="checkbox"/> Not stated	
Address			
Telephone		Email	
Medicare No		Reference No	Expiry
Interpreter <input type="checkbox"/> Yes <input type="checkbox"/> No		Language	
Indigenous status		<input type="checkbox"/> Not Aboriginal or Torres Strait Islander <input type="checkbox"/> Torres Strait Islander not Aboriginal <input type="checkbox"/> Aboriginal not Torres Strait Islander <input type="checkbox"/> Aboriginal and Torres Strait Islander <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Not specified	
Cultural considerations / support needs			
Contact Person		Name	
		Relationship	
		Telephone	
Reason for referral			
<input type="checkbox"/> Diagnostic clarification <input type="checkbox"/> Medication advice <input type="checkbox"/> Biopsychosocial Management Plan <input type="checkbox"/> Sensory profile <input type="checkbox"/> Single session family therapy <input type="checkbox"/> Other, list			
Presenting issues (include any symptoms and their duration, why you are referring now, specific questions you or the patient would like answered)			

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Gambling behaviours *(form, onset, frequency, debts)*

History of mental illness *(admissions, treatments or risky behaviours)*

Current medications *(name / dose / frequency)* or, attach a Medication List

How long have you been seeing this patient?

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What have you already tried?

Additional information

Names & addresses of other health professionals involved

<input type="checkbox"/> GP	
<input type="checkbox"/> Psychiatrist	
<input type="checkbox"/> Psychologist	
<input type="checkbox"/> Other, <i>list</i>	

Referrer Details	Date of Referral		Relationship	
Name		Address		
Telephone				
Fax		Email		

Consent

Verbal consent should be sought prior to a referral. If consent not granted, discuss with the Gambling Minds team

Return referral to: mhghvic@alfred.org.au

EMR: Referrals / Referral to Psychiatry

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