



NORTH METROPOLITAN AREA HEALTH SERVICE MENTAL HEALTH

REFERRAL FORM

Referring Clinician: _____ Referring Practice: _____

Telephone: _____ Fax: _____

Patient Surname: _____ Given Names: _____ Sex: _____

Address: _____ Suburb: _____

Postcode: _____ Date of Birth: _____ Country of Birth: _____

Telephone: (HOME) _____ (WORK) _____ (MOBILE) _____

Medicare No: _____ Ref: _____ Indigenous Status: _____

Is an Interpreter required? Yes No If Yes, what language? _____

Next of Kin/Carer: _____ Tel: _____ Relationship: _____

CAMHS (<18 years)	ADULT (18-65 years)	OLDER ADULT (>65 years)
Number of siblings? _____	Marital Status: _____	Known to ACAT? <input type="checkbox"/> Yes <input type="checkbox"/> No
School: _____	No. Dependent Children: _____	Veterans' Affairs? <input type="checkbox"/> Yes <input type="checkbox"/> No
Year: _____	No. Children at Home? _____	Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No

Reason for Referral: _____

Past Psychiatric History/ or Significant Family Issues: _____

Current/ Past Medical History: _____

Medications: _____

Investigations attached:

Urgency: Low Medium High

Current Risk Factors:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Suicidal ideation/behaviour | <input type="checkbox"/> Aggressive behaviour | <input type="checkbox"/> Self Harm |
| <input type="checkbox"/> Self neglect or accident | <input type="checkbox"/> Alcohol & other drug use | <input type="checkbox"/> Lives alone |
| <input type="checkbox"/> Vulnerable to abuse/exploitation | <input type="checkbox"/> Wandering | <input type="checkbox"/> Other: _____ |

Has the patient ever been in hospital because of psychiatric/psychological problems? Yes No
When? _____ Where? _____

Has the patient ever received counselling or therapy? Yes No
When? _____ Where? _____

Other agencies/professionals currently involved? Yes No
Whom: _____

Other Comments: _____

Has the referral been discussed with the client/parent/guardian? Yes No

Signature: _____ Date: _____

