NORTH METROPOLITAN AREA HEALTH SERVICE
MENTAL HEALTH

GENERAL PRACTITIONER 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? ☐ Yes ☐ No
School: ____	No. Dependent Children: ____	Veterans' Affairs? ☐ Yes ☐ No
Year: ____	No. Children at Home? ____	Guardian? ☐ Yes ☐ 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:

☐ *Suicidal ideation/behaviour*	☐ *Aggressive behaviour*	☐ *Self Harm*
☐ *Self neglect or accident*	☐ *Alcohol & other drug use*	☐ *Lives alone*
☐ *Vulnerable to abuse/exploitation*	☐ *Wandering*	☐ *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: ____________