OUTPATIENT PROGRAMS MENTAL HEALTH ASSESSMENT AND REFERRAL

Attach patient identification label

Patient Details

UR Number: ....

Surname: ....

Name: ....

Date of Birth: .... Gender: ....

Dr: ....

Private Health Fund: ______ *Membership Number:* ______

Inpatient Discharge date (if applicable): ___ ___ ___

Workcover: ☐ *TAC* ☐ *DVA* ☐ *Other Compensation*

Patient's Address:

______

______

Phone – Home ______ *Mobile* ______

DIAGNOSIS

1

2

3

REASON FOR REFERRAL / TREATMENT GOALS: ______

Psychiatric history and management (attach relevant information such as inpatient assessment / reports where available)

Substance Use History / Addictive Behaviours

Medical History

Family & Support Systems

☐ Supportive Family

☐ Family unsupportive

☐ Good social network

☐ Isolated

Please note any further comments

PSYCHIATRIC CARE IN COMMUNITY: Managed By (must see Accredited Hospital Psychiatrist at least 3 monthly)

______

Phone ______ *Mobile* ______ *Fax* ______

Community involvement

☐ Public health system ☐ Agency & CASA ☐ DHS

BINDING MARGIN – DO NOT WRITE IN THIS AREA

Print Media Group HSHGXFMR0520 03/19

OUTPATIENT PROGRAMS MENTAL HEALTH ASSESSMENT AND REFERRAL HMR 5.20

OUTPATIENT PROGRAMS MENTAL HEALTH ASSESSMENT AND REFERRAL

Attach patient identification label

Patient Details

UR Number: ....

Surname: ....

Name: ....

Date of Birth: .... Gender: ....

Dr: ....

CURRENT CLINICAL RISK TO PATIENT SAFETY:
Risk Rating: L = Low M = Moderate H = High risk – Rating H not suitable for Outreach or Day program

RISK	RATING			DETAILS
Suicidality	*L*	*M*	*H*	
Other Self Harm	*L*	*M*	*H*	
General Vulnerability	*L*	*M*	*H*	
Aggression / Harm to Others	*L*	*M*	*H*	
Judgment and impulsivity	*L*	*M*	*H*	
Forensic History / Pending legal issues	☐ *Yes*	☐ *No*		*Details* ______
Predatory	☐ *Yes*	☐ *No*		*List* ______

Medication	*Dose*	*Medication*	*Dose*

Compliance ☐ *Good* ☐ *Intermittent* ☐ *Poor*

Side Effects & Sensitivities

Precautions ☐ *Overdosing* ☐ *Hoarding* ☐ *Self Medicating*

Other

PROGRAM OPTIONS – Please (✓) programs, and where relevant specialist streams required for this patient
DAY PROGRAMS: Site to drop in DP / OR information.

SITE / FACILITY / HOSPITAL:

- ☐ *OUTREACH*
- ☐ *DAY PROGRAM: (please tick following)*
- ☐ *Mindful Self Compassion*
- ☐ *Mindfulness Based Cognitive Therapy (MBCT)*
- ☐ *Acceptance and Commitment Therapy (ACT)*
- ☐ *ACT in Practice*
- ☐ *ACT Graduates*
- ☐ *ACT Creatively*
- ☐ *ACT Wise Choices*
- ☐ *Deepening Mindfulness*
- ☐ *Bi-Polar Management Program (MAPS)*
- ☐ *Anxiety & Depression Program (ADP)*
- ☐ *Emotion Management Day Program (EMDP)*
- ☐ *Supporting Trauma and Recovery (STAR)*
- ☐ *PTSD General*
- ☐ *PTSD 000 for Emergency Services*
- ☐ *Eating Disorders Day Program*
- ☐ *Addictive Behaviour Day Program*
- ☐ *Dialectical Behavioural Therapy (DBT)*
- ☐ *Adult ADHD*
- ☐ *For Assessment*

By referring this patient, you agree to be responsible for the care and wellbeing of this patient in all matters relating to their Day Program participation, attendance, and / or mental state. Crisis care may also be sought if deemed necessary during the day program admission. Please provide your most direct contact number below.

Phone: ______________________ Emails will also be sent to you for non urgent matters.

Doctor's Signature: ______________________ Date: ______________

Thank you for your ongoing support of the Day Program.

Admin use

- ☐ Health fund check completed
- ☐ Booked into system
- ☐ Communication with psychiatrist
- ☐ Patient informed of HFC
- ☐ Communication with patient

BINDING MARGIN – DO NOT WRITE IN THIS AREA