



**OUTPATIENT PROGRAMS  
MENTAL HEALTH ASSESSMENT  
AND REFERRAL**

Attach patient identification label

UR Number: .....

Surname: .....

Name: .....

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

Dr: .....

Patient Details

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

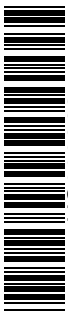
Mobile

Fax

**Community involvement**

- Public health system
- Agency & CASA
- DHS

BINDING MARGIN – DO NOT WRITE IN THIS AREA



HS000262

Print Media Group HSHGXFMR0520 03/19



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**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	<input type="checkbox"/> Yes <input type="checkbox"/> No			Details _____
Predatory	<input type="checkbox"/> Yes <input type="checkbox"/> 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:**

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



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