Healthscope

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

OUTPATIENT PROGRAMS MENTAL HEALTH ASSESSMENT AND REFERRAL HMR 5.20

BINDING MARGIN – DO NOT WRITE IN THIS AREA

HS000262

Print Media Group HSHGXFMR0520 03/19

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MENTAL HEALTH ASSESSMENT AND REFERRAL

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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:

Recovery & Support
Acceptance & Commitment Therapy Foundation
Acceptance & Commitment Therapy Wise Choices
Cognitive Behavioural Therapy
Interpersonal Group Therapy
Mindfulness Based Cognitive Therapy
Wise Wellness Tuesday or Friday

Early Parenting
Trauma Recovery
ART Therapy Monday half day or Thursday full day
Introduction to Mindfulness
Emotional Regulation Skills
Other_____

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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