**Booked Psychiatric Assessment** Referral Form

**Please note:** This service DOES NOT provide medico-legal reports e.g. for Centrelink, the courts, Workcover, or DSP Applications.

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| --- | --- | --- | --- | --- | --- |
| Date of Referral: |  | | | | |
| **Client Details** | | | | | |
| Name: |  | | | | |
| DOB: |  | | Gender: | |  |
| Address: |  | | Home number: | |  |
| Mobile number: | |  |
| Does the client identify as an Aboriginal or Torres Strait Islander? | | | | | Yes  No |
| Provisional diagnosis: |  | | Medicare number: | |  |
| **GP Details** | | | | | |
| Name: |  | | Provider number: | |  |
| Phone: |  | | Fax: | |  |
| Client consent / information given? | | | | | Yes  No |
| **Next of Kin Details** | | | | | |
| Name: |  | | Phone: | |  |
| Address: |  | | | | |
| **Please select your preference/s to be present at the case conference** | | | | | |
| Monday – 1.30 pm | | Monday – 3.00 pm | | Thursday – 12.30 pm | |
| Please call Sonder on 8209 0700 to discuss other options if these times are unsuitable. | | | | | |
| **Exclusion Criteria *(must complete this section)*** | | | | | |
| WorkCover Claim? | Yes  No | | Attention Deficit Disorder and/or Autism Spectrum Disorders | | Yes  No |
| Medico/Legal Issues? | Yes  No | | Intellectual Disability? | | Yes  No |
| DSP Application? | Yes  No | | | | |
|  |  | | | | |
| Presenting issues and relevant history: | | | | | |
|  | | | | | |
| **Previous Mental Health Services** | | | | | |
| **Mental Health Triage Service?** |  | | **Mental Health Services?** | |  |
| **NHN Mental Health Services?** |  | | **Other?** | |  |

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| --- |
| **Current Medications** |
| Medication List: |
|  |
| **Other Relevant Information** |
|  |
| **Office Use Only *(at date of booked assessment)*** |
| Client Signature: GP Signature: **Dr Rajan Nagesh Signature:** **MH Clinician Signature:** |

Please fax completed referral form to Sonder on (08) 8252 9433.