**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?** |  |

|  |
| --- |
| **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.