

OFFICE USE ONLY

PATIENT UMRN (IF KNOWN)

**Electronic Referral to Community Adult Mental Health Services**

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| **LOWER WEST CATCHMENT\***303 Rokeby RoadSubiaco WA 6008Tel: 9489 7200Fax: 9382 4171 | **WANNEROO CATCHMENT**2 Cafaggio CrescentWANNEROO WA 6065Tel: 9406 7100Fax: 9406 7190 | **STIRLING CATCHMENT**Unit 1/20 Chesterfield RdMIRRABOOKA WA 6061Tel: 9344 5400Fax: 9345 2631 |
| LowerWestCMH@health.wa.gov.au  | ReferralsWannerooCatchment@health.wa.gov.au | ReferralsStirlingCatchment@health.wa.gov.au |

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| **1. CLIENT DETAILS** | **2. DOCTOR/Referring Agency Details** |
| Name: |       | Name:       |
| DOB: |       | Male **[ ]**  Female **[ ]**  | Address:       |
| Address: |       |  |
|       |       |
| Postcode |       | Tel |       | Postcode: |       | Tel |       |
| Interpreter needed: **[ ]**   | Language Spoken:       | Fax: |       |
| Next of Kin/Contact Person  |       | Contact Number |       |

1. **Accommodation Status**

**Secure** **[ ]  Supported [ ]  Tenuous [ ]  Homeless [ ]  Not Known [ ]**

1. **Client’s Marital Status**

**Single [ ]  Married [ ]  Defacto [ ]  Separated [ ]  Divorced [ ]**

1. **Current Risk/Safety Issues – please indicate if this is high, medium or low**

**Suicide: Low [ ]  Medium [ ]  High [ ]**

**Violence: Low [ ]  Medium [ ]  High [ ]**

**Other Risk/Safety Issues (Please Specify):**

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1. **Reason for the referral of this client from your assessment providing as much relevant information to expedite the referral process?**

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1. **Past medical history/results of recent physical examination/result of recent investigations**.

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1. **Please list all medications taken by the client and other psychiatric medication proved ineffective**.

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| **Name of Medication** | **Dosage/Frequency** | **Date Commenced** | **Date Ceased** |
|       |       |       |       |
|       |       |       |       |
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|       |       |       |       |

**Signature:**       **Date:**

**Outcome of this Referral:**      Office Use Only