Mental Health Service – Adult and Older Adult GP Referral Form

Fremantle Hospital and Health Service
Alma Street Centre
PO Box 480, Fremantle. WA 6959
Adult Program: Tel: 9431 3555 Fax: 9431 3479
Older Adult Program: Tel: 93175600 Fax: 9317 6422

Adults 18 – 65 years and Older Adults 65 years+ ⇨ This Form Child up to 18 years ⇨ Contact Child and Adolescent Health Service, Tel: 94359700 Primarily alcohol / drug problem ⇨ Refer to Alcohol / Drug Service				
Referral to: Adult Program ☐	Older Adult Program ☐	Referral Date:		
Is this referral: Urgent ☐ discuss with Triage 94313555	Semi Urgent ☐	Routine ☐		
Family name:			Date of Birth:	Age:
Given Names:			Gender:	
Previous Names:			UMRN (*if known)*:	
Address:			Postcode:	
Telephone:	Home	Work:	Mobile:	
Marital Status S / M / W / D / Sep / De Facto				
Is client aware that this referral is to a psychiatric clinic:			Yes ☐	No ☐
Next of Kin / Primary care giver / Contact person name:				
Relationship to referred:				
Telephone:	Home	Work:	Mobile:	
Interpreter Required?	Yes ☐	No ☐		
If yes, language:	Preferred Interpreter:			
Case Manager (if involved with another agency):				
Telephone:				
Referring Doctor (stamp or print)			Provider No	
Name Address			Tel: Fax: Email:	
Are you the clients usual GP?			Yes ☐	No ☐

Client's Full Name:	DOB:

Reason for Referral

(Please use following prompts as a guide and elaborate- **Duration and history of problem -** include mood, appetite, sleep, thinking, perception, speech, memory; **Risk Factors -** suicide intent, past history of suicide attempts, threats to/from others. Aggression/violence, forensic history, confusion, self-neglect, wandering; **Past Medical History; Family History; Social History; Past and current drug and Alcohol use/misuse.**

Medications (Name, dose, frequency, when commenced)

Allergies / Drug Reactions / Special Needs

Doctor Name:		Signed:		Date:	