Austin Health

north east
primary mental health team

NEPMHT - Referral Form

Patient / Client	Referrer
Surname:	Name:
Given Names:	Referrer's address:
Address:	
	Phone:
Phone:	Fax:
Date of Birth:	Referral Date:
Gender: Male ☐ Female ☐	Does the client consent to referral? Yes No

Presenting Problems: (symptoms, duration, current level of functioning, level of distress, insight…etc)

Brief Personal History: (Social, employment, relationships, support)

Aim of Referral: (e.g. clarify diagnosis, review medication)

For triaging purposes, so we can prioritize our response to referrals are there any areas of immediate concern which would indicate that this patient needs to be seen more promptly? (e.g. risk, deterioration in mental state). Please give as much detail as possible:

Current Risk:

Suicidal Ideation: ☐ Suicidal Plans: ☐ Intent: ☐ Self Harm: ☐

Drugs & Alcohol:	Current Use:	Past Use:
List Substances:	☐	☐
	☐	☐
	☐	☐

Forensic History:

Violent Behaviour: ☐ Aggression towards professionals: ☐ Anger issues: ☐

Previous Psychiatric History:

Current medication:

Other providers *(eg. private psychologist, counsellor etc.)*:

1.

2.

Fax this form to NEPMHT on 9496-4394. If you wish to discuss the referral please call PMHT Mon-Fri 9-5pm on **9496-6489.** Please note, we do not provide case management, we provide a primary consultation including a psychiatric assessment, feedback and development of a treatment plan. For **urgent, acute psychiatric crisis assessment** contact NECMHS Triage **1300-859-789 (Option 3).**