

Referral Form

Calvary Clinic – Mental Health Unit

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name | | | | | | | | | D.O.B. | |
| Address | | | | | | | | | | |
|  | | | | | | | | | Phone | |
| Referral to Dr | | | | | | | | Date to be admitted: | | |
| INSURANCE DETAILS | | | | | | | | | | |
| **Health Insured 🞏**  Fund:  Member No: | | | **Workers Comp 🞏**  Contact Name:  Number: | | | | | **Veterans Affairs 🞏**  DVA No: | | **MAIB 🞏** |
| **Admission Diagnosis** |  | | | | | | | | | |
| **Current Medical Conditions** |  | | | | | | | | | |
| RISK ASSESSMENT | | | | | | | | | | |
| Description | | Low | | Moderate | High | Extreme | If present – please elaborate | | | |
| Suicidality/Homicidality Thoughts/Plan/Intention | |  | |  |  |  |  | | | |
| Deliberate Self Harm | |  | |  |  |  |  | | | |
| Aggression – Physical and/or Verbal (including threats) | |  | |  |  |  |  | | | |
| Drug and Alcohol Use | |  | |  |  |  |  | | | |
| Cognitive Impairment | |  | |  |  |  |  | | | |
| Other | |  | |  |  |  |  | | | |

Referring Doctor’s Name:………………………………………………………………(please print)

Signature: ………………………………………….

|  |  |
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| INITIAL CONTACT | Please phone (03) 6335 3249 then fax this completed form to (03) 6335 3248 |