

Referral Form

Calvary Clinic – Mental Health Unit

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| --- | --- |
| 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 |