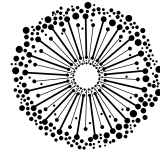


# Referral/Admission Form

SPECIALIST TREATMENT AND RECOVERY MENTAL HEALTH SERVICES



THE  
HOBART  
CLINIC

INPATIENT

Depression  
Anxiety  
Addictions  
Aged Psychiatry

COURSES AND PROGRAMS

Wellbeing Courses  
Group Therapy Sessions  
Recovery Programs

T 03 6247 9960

F 03 6247 6439

E [admissions@thehobartclinic.com.au](mailto:admissions@thehobartclinic.com.au)

[www.thehobartclinic.com.au](http://www.thehobartclinic.com.au)

## REFERRAL DETAILS

NAME \_\_\_\_\_ DOB \_\_\_\_\_

ADDRESS \_\_\_\_\_

EMAIL \_\_\_\_\_ PHONE \_\_\_\_\_

PRIVATE HEALTH FUND \_\_\_\_\_ MEMBERSHIP NUMBER \_\_\_\_\_

REASON FOR REFERRAL (Please attach further documentation if required)

SIGNIFICANT PAST HISTORY

CURRENT MEDICATIONS

## RISK ASSESSMENT

	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 abuse					
Cognitive Impairment					
Medical complications					
Other					

## REFERRING DOCTOR/CLINICIAN

NAME \_\_\_\_\_

PROVIDER NO. \_\_\_\_\_ SIGNATURE \_\_\_\_\_

OFFICE USE ONLY

HEALTH FUND CHECK RESULT

EASTERN SHORE  
31 Chipmans Road  
Rokeby TAS 7019

CITY  
Level 1/175 Collins St  
Hobart TAS 7000