Referral/Admission Form

SPECIALIST TREATMENT AND RECOVERY MENTAL HEALTH SERVICES

MIND HUB COURSES & PROGRAMS | 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
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