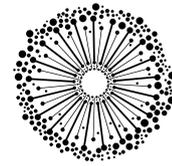


Referral/Admission Form

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THE
HOBART
CLINIC

Evidence in Mental Health

PATIENT DETAILS

SURNAME _____ DOB _____

FIRST NAME _____

ADDRESS _____

EMAIL _____

MOBILE _____ WORK _____ HOME _____

Do you give permission to receive SMS notifications or voicemail on the above numbers? Yes No

MEDICARE NUMBER _____ PRIVATE HEALTH INSURANCE NUMBER _____

Expiry: _____ Expiry: _____

HEALTHCARE CARD NUMBER _____ THIRD PARTY INFORMATION _____

Expiry: _____ (i.e WCC or MAIB)

CULTURAL BACKGROUND

DOES THE PERSON IDENTIFY AS? Aboriginal Torres Strait Islander Both Aboriginal and Torres Strait Islander Neither

PREFERRED LANGUAGE IF OTHER THAN ENGLISH: _____ Interpreter Required: Yes No

COUNTRY OF BIRTH: _____

NEXT OF KIN DETAILS

NAME _____ RELATIONSHIP _____

PHONE NUMBER _____

EMERGENCY CONTACT (if different from above) _____ PHONE _____

GOAL OF ENGAGEMENT

ADMISSION OUTPATIENT DAY PROGRAMS

REASON FOR REFERRAL/PATIENTS' CURRENT SITUATION: _____

DIAGNOSIS _____

If the patient is a current inpatient, please attach the admission note, recent nursing notes, any relevant legal orders for example Guardianship paperwork.

Referral/Admission Form

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PATIENT SURNAME

PATIENT FIRST NAME

MEDICAL INFORMATION

PSYCHIATRIC HISTORY

Please attach any recent pathology results

MEDICATIONS AND ALLERGIES

If applicable attach drug chart or medication summary

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 | | | | | |

REFERRER DETAILS

GP PSYCHIATRIST PSYCHOLOGIST

NAME

CLINIC

PHONE

FAX

PROVIDER NO.

SIGNATURE

DATE