Referral/Admission Form

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THE HOBART CLINIC
Excellence 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.

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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

TF95 APPROVED V3 Review: 31/05/2024