

Mental Health Service Adult and Older Adult GP Referral Form

Fremantle Hospital and Health Service

Alma Street Centre

PO Box 480, Fremantle. WA 6959

Adult Program: Telephone No: 9431 3555 Fax No: 9431 3479

Older Adult Program: Telephone No: 93175600 Fax No: 93176422

Child up to 18 years ⇒ Use CAMHS Referral Form

Adults 18 – 65 years ⇒ This Form

Seniors 65 years + ⇒ This Form

Primarily alcohol / drug problem ⇒ Refer to Alcohol / Drug Service

Family name	Hospital UMRN (if known)
Given Names	
Gender	Date of Birth
Address	
	Postcode

Referral Date _____

Is this referral: Urgent Routine

Other Client Details

Telephone: Home _____ Work _____

Marital Status: S / M / W / D / Sep / De Facto

Ethnic Identity _____

Interpreter Required: Yes No Language _____

Preferred Interpreter _____

Is client aware that this referral is to a psychiatric clinic: Yes No

Next of Kin / Primary care giver / Contact person _____

Relationship _____ Contact Telephone _____

Case Manager (if involved with another agency) _____

Referring Doctor (stamp or print)

Name _____ Provider No _____

Address _____

Postcode _____

Telephone _____ Fax _____

Email Address _____

Are you the clients usual GP? Yes No

Reason for Referral



Client's Full Name _____

Current Treatment / Management Plan

Please list client's current medication / treatment

Medication/Treatment	Commenced	Dosage	Frequency

Allergies / Drug Reactions / Special Needs / Requirements

Presenting Problem Please use guide on the left and elaborate

**Duration & History
Of Problem**

- Mood
- Appetite
- Sleep
- Thinking
- Perception
- Speech
- Memory

Risk Factors

- Suicide Intent
- Threats to/from others
- Aggression/Violence
- Forensic History
- Wandering
- Confusion
- Self Neglect

Medical

- Conditions
- Recent Examinations
- Recent Investigations
- Previous psychotic Medications

History

- Family & Personal Psychiatric History
- Past & Current
- Alcohol / Illicit Drug Misuse

Recent Stressors

- Family
- Relationships
- Financial
- Accommodation
- Employment

**Any Other Services
Involved**

This referral will be discussed at the team intake meeting. You will be informed of the outcome.

Doctor's Signature _____

Date _____

