Albany SUSD – REFERRAL FORM

Name: _____ Address: _____ _____ P/code_____ Phone : _____ DOB: ___ /___ /_____ Gender Consumer Identifies with: Identify as Aboriginal or Torres Strait Islander? ***Please note, referrals for under 18's need to be completed by medical staff (GP/psychiatrist)****	Referrer Name: _____ Designation: _____ Service: _____ Contact: _____ Email: _____ Referral Date: ___ /___ /_____ Step Up ☐ Step Down ☐ Inpatient ☐ Yes ☐ No If Yes, Date of Admission: ___ /___ /_____ Estimated Date of Discharge: ___ /___ /_____
Consumer has been Informed of Referral: **Consumer is aware that they are required to participate in Optimal Health Program during stay?**	☐ Yes ☐ No ☐ Yes ☐ No
Under 18's guardian or NOK – Consent obtained	☐ Yes ☐ No (consent required for assessment to occur)

CASE MANAGER ACKNOWLEDGEMENT	Case Manager will continue normal treatment responsibilities including monitoring, review and re-assessment ☐ Yes ☐ No

CLINICAL CARE

Psychiatrist Details:	TEL:	
GP Details:	TEL:	
Other:	TEL:	

REASON FOR REFERRAL

PSYCHIATRIC HISTORY Including date of last hospital admission

Precipitants History of current Episode & treatment Signs & Symptoms - hallucinations - abnormal ideation - preoccupations - suicidal ideation - aggressive - anxiety states - mood disturbance - sleep - appetite - substance abuse Other disability IDS/Physical Clients perception of problem Demographics	DIAGNOSIS / date given PRESENTING PROBLEM/S (Referrer's Perceptions) **Case Management Strategies:**

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MEDICATION	Last Medication Review date:	
Current Medication:		
Depot Information:		
	Next Due:	Frequency:
Adverse Reactions:		
Medication Compliance:		

RISK ASSESSMENT	Alerts/Safety Issues:
	Brief Risk Assessment attached: ☐ Yes ☐ No
Drug/Alcohol Issues:	
Legal/Forensic Issues:	CTO: ☐ Yes ☐ No

CURRENT CIRCUMSTANCES
Housing:
Next of Kin and/or Carer Details:
Dependents (Children/Elders):

Email referral to
albany@neaminational.org.au
Phone 08 6362 8900

OFFICE USE ONLY:	Completed by Service Manager:		
ASSESSMENT OUTCOME	Referral Accepted	☐ YES	☐ NO
If No, please provide details:			
Consumer advised by:		Date:	
Referrer advised by:		Date:	