The RB&WH Health Service Districts
Division of Mental Health Services

GP Psych Opinion

G.P. TO PSYCHIATRIST CONSULTATION REFERRAL FORM

Fax to: 3636 1784
Private Practice Clinic
Royal Brisbane Hospital

PATIENT DETAILS
(*Please print Clearly*)

NAME: ………………………………………………

ADDRESS: ………………………………………

…………………………………………………………..

PHONE: ……………………………………………

DOB .. ../…../…… Male Female

Date: ____/____/____

GP Name: ______________________________ Provider No:____________

Address: ____

Phone: __________________ Fax: __________________

Do you work in the RBH Catchment area ? **Yes.** **No.**

Does your patient live in the RBH Catchment Area ? **Yes** **No.**

Has the patient been informed this is an Assessment Service only ? **Yes** **No.**

Do you want telephone feedback from the Psychiatrist ? **Yes** **No.**

What is the main reason for referral ?

Diagnosis	☐	**Development of Management Plan**	☐
Review of Diagnosis	☐	**Review of Management Plan**	☐

PROVISIONAL DIAGNOSIS: (Please tick – more than one box can be ticked)

Major Depression		Anxiety		Personality Disorder	
Bipolar Disorder		Substance Abuse		Adjustment Disorders	
Schizophrenia		Organic Disorder		Other	

Summary of Problem

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CURRENT MEDICATION:

Drug	Dose	Date Initiated	Response

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GP PSYCH OPINION - GP TO PSYCHIATRIST - CONSULTATION REPORT

Trial - 4/6/01

ALLERGIES:

RELEVANT HISTORY (Medical, Surgical, Social , Family)

CURRENT MANAGEMENT PLAN:

Signature: ____________________________ **Print Name:** ____________________________

Date: ____/____/____ **Designation:** ________________________________

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