

Royal Brisbane & Women's Hospital
Health Service District

RBWH Mental Health

Referral Form

(Internal or External Referrals)

PATIENT IDENTIFICATION LABEL:

UR No.:

Surname:

Given Names:

DOB:/...../..... Male Female
(or affix patient ID label here)

N.B. Please attach any additional information that will be of assistance

Date Referral Made: ____ / ____ / ____

Patient Address:

Suburb: _____ Postcode: _____ State: _____

Phone No: Home: _____ Mobile: _____ Work: _____

Referrer Details:

Name: _____ Relationship: _____

Organisation:

Address:

Phone No:

Referral Request: *(Please tick)*

<input type="checkbox"/> Acute Care Team (for all new referrals)	<input type="checkbox"/> Community Care Unit	<input type="checkbox"/> Alcohol & Drug Service Consultation Liaison (RBWH referral only)
<input type="checkbox"/> Case Management (North or South Team)	<input type="checkbox"/> Geriatric Psychiatry Outreach Service	<input type="checkbox"/> DBT Program
<input type="checkbox"/> Medical Management	<input type="checkbox"/> Eating Disorder Outreach Service	<input type="checkbox"/> CBT Program (anxiety & Depression, Auditory Hallucinations)
<input type="checkbox"/> Acute Care – After Hours	<input type="checkbox"/> Alcohol & Drug Service	<input type="checkbox"/> Early Intervention Program
<input type="checkbox"/> Mobile Intensive Treatment Team	<input type="checkbox"/> Adolescent Psychiatry	<input type="checkbox"/> Other Program (please specify)

Key Stakeholders: *(Include name, designation, address and contact details)*

Team (specify):	Medical Officer:
Case Manager:	GP:
Other Service Provider:	Next of Kin/Significant Other/Allied person:

Risk Factors / Alerts *(Violence, suicide, animals, access to weapons, lethal drugs etc)*

Relevant Treatment Information:	Current Medication:
MH Status: _____ Expiry Date: _____	
Current Diagnoses:	
Psychiatric: _____	
Medical: _____	
Planned Discharge Date: _____	Next Doctor's Appointment: _____



