

OFFICE USE ONLY

PATIENT UMRN (IF KNOWN)

**Electronic Referral to Community Adult Mental Health Services**

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| **LOWER WEST CATCHMENT\***  303 Rokeby Road  Subiaco WA 6008  Tel: 9489 7200  Fax: 9382 4171 | **WANNEROO CATCHMENT**  2 Cafaggio Crescent  WANNEROO WA 6065  Tel: 9406 7100  Fax: 9406 7190 | **STIRLING CATCHMENT**  Unit 1/20 Chesterfield Rd  MIRRABOOKA WA 6061  Tel: 9344 5400  Fax: 9345 2631 |
| [LowerWestCMH@health.wa.gov.au](mailto:LowerWestCMH@health.wa.gov.au) | [ReferralsWannerooCatchment@health.wa.gov.au](mailto:ReferralsWannerooCatchment@health.wa.gov.au) | [ReferralsStirlingCatchment@health.wa.gov.au](mailto:ReferralsStirlingCatchment@health.wa.gov.au) |

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| **1. CLIENT DETAILS** | | | | | | | **2. DOCTOR/Referring Agency Details** | | | |
| Name: |  | | | | | | Name: | | | |
| DOB: |  | | | | | Male  Female | Address: | | | |
| Address: | |  | | | | |  | | | |
|  | | | | | | |  | | | |
| Postcode | |  | Tel | |  | | Postcode: |  | Tel |  |
| Interpreter needed: | | | | Language Spoken: | | | Fax: |  | | |
| Next of Kin/Contact Person | | | |  | | | Contact Number |  | | |

1. **Accommodation Status**

**Secure**  **Supported  Tenuous  Homeless  Not Known**

1. **Client’s Marital Status**

**Single  Married  Defacto  Separated  Divorced**

1. **Current Risk/Safety Issues – please indicate if this is high, medium or low**

**Suicide: Low  Medium  High**

**Violence: Low  Medium  High**

**Other Risk/Safety Issues (Please Specify):**

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1. **Reason for the referral of this client from your assessment providing as much relevant information to expedite the referral process?**

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1. **Past medical history/results of recent physical examination/result of recent investigations**.

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1. **Please list all medications taken by the client and other psychiatric medication proved ineffective**.

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| **Name of Medication** | **Dosage/Frequency** | **Date Commenced** | **Date Ceased** |
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**Signature:**       **Date:**

**Outcome of this Referral:**      Office Use Only