Government of **Western Australia**
Department of **Health**
Rockingham Peel Group

PEEL ADULT COMMUNITY MENTAL HEALTH SERVICE

CLIENT REFERRAL INFORMATION

110 Lakes Road, Mandurah WA 6210 - PO Box 162, Mandurah WA 6210
Ph: (08) 9531 8080 Fax: (08) 9531 8070

ROCKINGHAM PEEL GROUP MHS PROVIDES SERVICES TO ADULTS WITH A PRIMARY DIAGNOSIS OF MENTAL ILLNESS WHO REQUIRE SPECIALIST MENTAL HEALTH CARE

CLIENT DETAILS

Name: _____ Male / Female DOB: _____

Address: _____ Postcode: _____

_____

Phone: (Home) _____ (Work / Mobile) _____

WHO IS THE PERSON'S MAIN SUPPORT

Name: _____ Relationship: _____ Phone: _____

IS THE PERSON AWARE OF THE REFERRAL AND DO THEY AGREE? ☐ Yes ☐ No

DO THEIR CARER / FAMILY HAVE ANY CONCERNS? _____

_____

REASON FOR REFERRAL (When did it start? Action / remedy to date? Main symptoms?)

_____

_____

RISK ASSESSMENT

Self Harm ☐ Ideation ☐ Past History ☐ Means Available ☐ Intent / Plan

Harm to others ☐ Ideation ☐ Past History ☐ Means Available ☐ Intent / Plan

Describe Risk (Include intent / plan, previous, lethality, duration, hopelessness, intoxication, known psychiatric issues, pain, loss)

_____

_____

Please indicate the CURRENT concern/s prompting this referral:

Psychotic phenomena: ☐

Hallucinations: ☐ Auditory ☐ Command ☐ Visual ☐ Tactile ☐ Olfactory

Details _____

_____

Disorders in mood / affect: ☐

☐ Physiological shift symptoms (sleep, appetite, energy) ☐ Depression ☐ Elevation

☐ Hostility ☐ Cognitive symptoms ☐ Irritability ☐ Hopelessness / Helplessness

☐ Worthlessness ☐ Anxiety ☐ Anger ☐ Aggression

Details _____

_____

☐ Panic Attacks / Disorder

☐ Generalized anxiety and/or phobia

☐ Severe obsessions and compulsive rituals

☐ PTSD / trauma symptoms

☐ Somatic (no physiological source)

☐ Bizarre, unusual behaviour

☐ Severe behavioural and conduct disturbance

☐ Grief / loss / separation issues

☐ Eating disorders and severe body image issues

☐ Inappropriate sexual behaviour

ANY RECENT PRECIPITANTS OR STRESSORS? ☐ Yes ☐ No

☐ Family ☐ Relationship ☐ Financial ☐ Accommodation ☐ Employment

Other _____

HISTORY OF VIOLENCE / CRIMINAL CHARGES? ☐ Yes ☐ No

HAS THERE BEEN ANY RECENT SUBSTANCE ABUSE OR CESSATION? ☐ Yes ☐ No

Which substance/s? _____

PAST MEDICAL HISTORY

PLEASE DOCUMENT PHYSICAL EXAMINATION: – Date completed ____/____/____

ARE ANY OTHER AGENCIES INVOLVED IN THE CARE OF THE CLIENT OR THEIR DEPENDANTS?

☐ Yes ☐ No _____

Please ensure copies of all investigations that have been undertaken in the last 12 months are attached to this referral.

PLEASE LIST ALL CURRENT MEDICATIONS

Medication	Commenced	Dosage	Frequency

PREFERRED TREATMENT REQUEST

☐ Routine community assessment ☐ GP Liaison assessment (in GP Surgery) ☐ Medical assessment/review

DESIRED RESPONSE TO THIS REFERRAL?

☐ Routine

☐ Urgent (2-5 days) **If requiring more urgent attention contact the duty officer or local Emergency Department*

DOCTOR / REFERRER'S CONTACT DETAILS

Name (please print) _____

Address _____

_____

STAMP

Postcode _____ Telephone _____ Facsimile _____

Signature _____ Date ____/____/____

Thank you for your referral and following clinical discussion, referring GP and referred client will be contacted to discuss outcome and proposed action plan.