



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 Bizarre, unusual behaviour
 Generalized anxiety and/or phobia Severe behavioural and conduct disturbance
 Severe obsessions and compulsive rituals Grief/loss/separation issues
 PTSD/trauma symptoms Eating disorders and severe body image issues
 Somatic (no physiological source) 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 Medical assessment/review
(in GP Surgery)

DESIRED RESPONSE TO THIS REFERRAL?

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

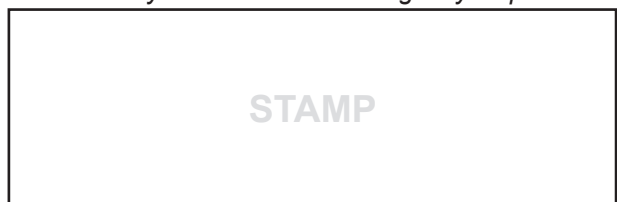
DOCTOR/REFERRER'S CONTACT DETAILS

Name (please print) _____

Address _____

Postcode _____ Telephone _____

Signature _____



Facsimile _____

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.