RHC100.20 Referral/Consent

The Southport Private Hospital
Part of Ramsay Health Care

Psychiatrist Referral Form

UR No: _____

Surname: _____

Given Name: _____

D.O.B: _____ Sex: _____

(Affix Patient Identification label here)

Clinical Details / Reason for Referral

Inpatient Admission: ☐ Mood Disorder ☐ Eating Disorder ☐ Elderly Assessment ☐ TMS

Admission Urgency: ☐ Crisis ☐ Urgent ☐ Elective ☐ Voluntary

Day Patient Programs: ☐ ECT - Day Patient

Support ☐ Social Development

Anxiety & Mood Disorder ☐ CBT ☐ CBT Evening ☐ Life Skills ☐ TMS

Eating Disorder ☐ MBT ☐ Anorexia Nervosa

Personality Disorders & Self Harm ☐ Intro to DBT ☐ DBT ☐ DBT 18-25 ☐ DBT Evening ☐ Adv DBT ☐ Adolescent DBT

Community Outreach: ☐ Please complete referral on back

Provisional Diagnosis:

Reason for Referral:

Management Plan / Discharge Plan / Discharge Date:

Other Conditions / Special Needs:

Risk Assessment

Patient Observation Category	☐ 1	☐ 2	☐ 3	☐ 4
Suicide:	☐ High	☐ Moderate	☐ Low	
Self Harm:	☐ High	☐ Moderate	☐ Low	
Absconding:	☐ High	☐ Moderate	☐ Low	
Aggression:	☐ High	☐ Moderate	☐ Low	
Substance / Alcohol Use:	☐ High	☐ Moderate	☐ Low	
Vulnerabilities:	☐ High	☐ Moderate	☐ Low	

Referring Doctor Details - or stamp

Name: _____ Provider No: _____

Signature: _____ Date: _____

BINDING MARGIN - DO NOT WRITE

PSYCHIATRIST REFERRAL FORM 2

The Southport Private Hospital
Part of Ramsay Health Care

Community Outreach Referral

UR No: _____

Surname: _____

Given Name: _____

D.O.B: _____ Sex: _____

(Affix Patient Identification label here)

Admission Details

Admission Date: Discharge Date:

Diagnosis:

Brief History:

Risk Screen: Past History of

☐ Suicide ☐ Self Harm ☐ Aggression ☐ Substance / Alcohol Use ☐ Social Isolation

Expected Goals of Community Outreach

1.

2.

3.

Written Reports: ☐ Weekly ☐ Fortnightly ☐ Monthly

Follow-up Arrangements:

Day Program (Please Specify): ☐ _____

Outpatient Appointment: ☐ _____

Involuntary Treatment Order (Community): ☐ _____

NB: Patients who are discharged under an Involuntary Treatment Order, Mental Health Act 2000, must be seen or contacted by an Outreach Case Manager within 7 days from the discharge date.

NB: Please attached copy of Discharge Summary

Referring Doctor Details

Psychiatrist Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Case Manager Signature: _____ Date: _____