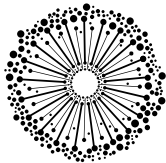


Referral/Admission Form

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THE
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Excellence in Mental Health

PATIENT DETAILS

SURNAME		DOB
FIRST NAME		
ADDRESS		
EMAIL		
MOBILE	WORK	HOME
Do you give permission to receive SMS notifications or voicemail on the above numbers? <input type="checkbox"/> Yes <input type="checkbox"/> No		
MEDICARE NUMBER	PRIVATE HEALTH INSURANCE NUMBER	
Expiry:	Expiry:	
HEALTHCARE CARD NUMBER	THIRD PARTY INFORMATION	
Expiry:	(i.e WCC or MAIB)	

CULTURAL BACKGROUND

DOES THE PERSON IDENTIFY AS? ☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander ☐ Neither

PREFERRED LANGUAGE IF OTHER THAN ENGLISH: Interpreter Required: ☐ Yes ☐ No

COUNTRY OF BIRTH:

NEXT OF KIN DETAILS

NAME	RELATIONSHIP
PHONE NUMBER	
EMERGENCY CONTACT (if different from above)	PHONE

GOAL OF ENGAGEMENT

☐ ADMISSION ☐ OUTPATIENT ☐ DAY PROGRAMS

REASON FOR REFERRAL/PATIENTS' CURRENT SITUATION:

DIAGNOSIS

If the patient is a current inpatient, please attach the admission note, recent nursing notes, any relevant legal orders for example Guardianship paperwork.

Referral/Admission Form

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PATIENT SURNAME

PATIENT FIRST NAME

MEDICAL INFORMATION

PSYCHIATRIC HISTORY
Please attach any recent pathology results

MEDICATIONS AND ALLERGIES
If applicable attach drug chart or medication summary

RISK ASSESSMENT

	LOW	MODERATE	HIGH	EXTREME	IF PRESENT PLEASE ELABORATE
Suicidality/Homicidality Thoughts/Plan/Intention					
Deliberate Self Harm					
Aggression – Physical and/or verbal (including threats)					
Drug and alcohol abuse					
Cognitive Impairment					
Medical complications					
Other					

REFERRER DETAILS

☐ GP☐ PSYCHIATRIST☐ PSYCHOLOGIST

NAME

CLINIC

PHONE

FAX

PROVIDER NO.

SIGNATURE

DATE