FS501080

FIONA STANLEY HOSPITAL

YOUTH COMMUNITY ASSESSMENT TREATMENT TEAM

SURNAME	UMRN
GIVEN NAMES	DOB
ABORIGINAL or TSI:	GENDER
ADDRESS	
	PHONE

FROM (Referring Agency)

Referrer:		Phone:
Next of Kin/nominated person's name:		Phone:
GP:	Practice:	Phone:
Does the client agree to the referral?	☐ Yes ☐ No	Date of referral:

PRESENTING COMPLAINT / REASON FOR REFERRAL

RISK ASSESSMENT

Risk of harm to self:	☐ Low	☐ Medium	☐ High	☐ Unknown
Risk of harm to others:	☐ Low	☐ Medium	☐ High	☐ Unknown
Risk of harm to children/pets:	☐ Low	☐ Medium	☐ High	☐ Unknown
Vulnerability:	☐ Low	☐ Medium	☐ High	☐ Unknown

Comments:

ANY OTHER RELEVANT HISTORY

Past psychiatric history:

Medical history:

Current medications:

Substance use history (Inc. alcohol and other drugs):

Family history:

Forensic history:

Please send referral to: FSH.YouthCommunity@health.wa.gov.au

Fiona Stanley Mental Health Unit Reception: 6152 7999 **Fax: 6152 4216**

YOUTH COMMUNITY ASSESSMENT TREATMENT TEAM REFERRAL