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

ROCKINGHAM KWINANA ADULT MENTAL HEALTH SERVICE

CLIENT REFERRAL INFORMATION

Cnr Clifton & Ameer Street, Rockingham WA 6168 - ParkMHSRKATT@health.wa.gov.au
Ph: (08) 9528 0600 Fax: (08) 9529 1266

We are a specialist mental health service, offering treatment for severe and enduring mental illness. We are unable to facilitate assessments for ADD / ADHD, Autism, reports for court, workers compensation or DSP / NDIS. This requires a referral to a private psychiatrist.

1. Client Details:		**2. Doctor / Referring Agency Details / Stamp:**
Name:		Name: Practice: Address: Tel: Fax: E-mail:
DOB:	Gender:	
Address:		
Tel:		
Ethnicity: Aboriginal: Torres Strait Islander:	Language / interpreter needed:	
Next of Kin / Contact Person:		
Phone:		Date of referral:

3. Prior to referring the client please review these questions:

If indicated has the person had at least 6 weeks trial of psychiatric medication? Yes ☐ No ☐

If indicated has a Mental Health Treatment Plan been initiated? Yes ☐ No ☐
Please note individual psychology sessions are not offered by our service under a MHTP.

Have medical causes for the presentation been investigated and excluded? Yes ☐ No ☐
Please indicate below:

Have any of the following primary services been considered / utilised?

South Metro Drug and Alcohol – 9550 9200 ☐

ALIVE – 360 Suicide Prevention Program – 1300 706 922 ☐

Aboriginal Services – Babbingur Mia – 9550 0900 ☐ Moorditj Koort 6174 7000 ☐
Wungening 9221 1411 ☐ (state wide, AOD counselling at Rockingham)

PORTS – Practitioner Online Referral Treatment Service – 1800 176 787 ☐

Headspace – Services for 12-25 years old – 6595 8888 ☐

Mental Health Connext – Community Support – 1800 532 012 ☐

ARBOR – Bereavement by suicide – 9263 2150 ☐

Psychosocial Support e.g RUAH / NEAMI / other ☐

The above and other resources can be found at https://wa.healthpathways.org.au/15718.htm

4. Following your assessment of the client please detail the reason for the referral. Provide as much relevant information to expedite the referral process; including Mental State Examination, past psychiatric history and concerns from family / support network.

5. Please indicate any current or previous risk to self or others (Self-harm, suicidal ideation, plan / intent, thoughts of harming others, please detail how / when / who, detail any history):-

6. Please list all current medications taken by the client and duration. Please list any psychiatric medications previously prescribed which have been reported as ineffective.

Medication, Commenced, Dosage, Frequency	Previous medication reason for ceasing

- Please attach medication summary.

7. Please provide contact details of the client's main support and any other agencies involved in care of the client or their dependents:-

8. Other relevant information:-

Relevant Previous Medical History including recent investigation:

Drug and Alcohol History (include type, quantity, frequency, administration and when last used):

History of violence and criminal charges, type and criminal charges (when and what).
Any pending court cases?:

9. Preferred response to the referral:

- ☐ Medical Phone consultation for advice on management / medication.
- ☐ Case conference – At your practice with the client, our Clinical Nurse Specialist and Psychiatrist – arranged via our CNS.
- ☐ Comprehensive Mental Health Assessment and Opinion.

If this referral requires a more URGENT response please submit a completed form and contact our triage officers on 9528 0600 to discuss or utilise the local Emergency Department. If after hours MHERL can be contacted on 1300 555 788.

Incomplete forms may potentially cause delays in processing this referral.

Thank you for you referral, all referrals are discussed the next business day at the Multi-disciplinary Team meeting. The referrer and client will be contacted to discuss the outcome and proposed action plan.