REQUEST FOR CONSULTATION

GOLD COAST HOSPITAL AND HEALTH SERVICE

**MENTAL HEALTH CLINIC**

**ADULT AND OLDER PERSONS**

**COMMUNITY ONLY**

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| **SEND TO** Dr Ravi Krishnaiah (Director of Community Mental Health)  Acute Care Team Community Intake  Fax: 07 5687 7370  **OR**  **Secure transmission service via Medical Objects or**  **Healthlink to**  **QHEALTH,GOLD COAST HEALTH Outpatients**  **Outpatient Bookings and Referrals** | **FROM**  **Doctors Name:**  **Practice Name:**  **Practice Address:**  **Phone:**  **Fax:**  **Email:**  **Provider Number:** |

**In emergency and more urgent cases, please contact the Acute Care Treatment Team on 1300 642 255**

Dear Dr Krishnaiah

**SECTION 1 Patient details**

**Patient Full Name:**

**DOB:**

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| **Gender:**  **Address:**  **Home Ph**:  **Mobile Ph:**  **Medicare Number\*:**  (\*Medicare ineligible patients will incur a consultation fee) | **Next of Kin/Alternative Contact:**  **Next of Kin/Alternative Contact Ph:**  **Does patient identify as Aboriginal and/or Torres Strait**  **Islander:**  **Interpreter required:**  **If yes, specify language:** |
| **SECTION 2 Reason for referral and additional clinical information** | |

What is the reason for this referral:

Please provide provisional diagnosis (if available):

Please include any symptoms and date of onset (if known):

**Paste or type relevant history, clinical examination findings and treatment to date if required**

Please include any information relating to: vulnerability factors, legal issues (e.g. court dates, child safety issues, employment/carer responsibilities, domestic violence), children and other dependents.

**SECTION 3 Mandatory clinical information**

Previous diagnosis of mental health disorders:

If yes, please specify:

Previous MH admission or MH specialist treatment:

If yes, please specify:

What is the risk of suicide/self-harm:

Are there risk factors for others:

If yes, please specify:

**SECTION 4 Investigations**

No 'pre-requisite' information required however, please attach any investigation, result or correspondence you consider to be relevant.

**SECTION 5 Duration of referral**

Please indicate how long you would like your referral to remain valid:

☐ 12 months

☐ Indefinite

Indefinite referrals do not expire until the patient has been discharged by the hospital service. When referrals expire, there is an expectation that the referring GP or another GP will review the care of the patient. If the patient still requires specialist care, the GP will then have to request a referral continuation.

**SECTION 6 Social factors and impact on the patient**

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| Consider the impact on employment/education; activities of daily life; ability to care for others; personal safety/frailty;  other factors. **Please paste or type relevant information.** |

**SECTION 7 Medical history including co-morbidities and previous surgical interventions**

**Alcohol Status/History:**

**Smoking Status/History:**

**Medical History:**

**Comorbidities:**

**Previous Procedures:**

**Allergies/Adverse Reactions:**

**Current prescribed medications:**

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| **SMOs/VMOs in this Specialist Service** |

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| Dr Ravi Krishnaiah (Director) |