REQUEST FOR CONSULTATION

GOLD COAST HOSPITAL AND HEALTH SERVICE

**PERINATAL MENTAL HEALTH CLINIC**

Template for initial referral of patients

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| **SEND TO** Dr Susan Roberts (Clinical Lead and Perinatal Psychiatrist)  **Fax completed referrals to: 07 5687 7814** | **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 Roberts

**SECTION 1 Patient details**

**Patient Full Name:**

**DOB:**

|  |  |
| --- | --- |
| **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**

**SECTION 3 Mandatory clinical information**

Is this patient pregnant or postpartum:

Please specify:

Is there a history of previous serious mental health disease:

If yes, please specify:

Has patient been admitted to a mental health unit before:

If yes, please specify:

Are there concerns about risk to self/children/others:

If yes, please specify:

**SECTION 4 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; family and relationships;  other factors. Please paste or type relevant information. |

**SECTION 5 Investigations and previous mental health correspondence**

Did the patient complete the Edinburgh Post-natal Depression Survey:

If yes, please indicate:

**Please attach or list any investigation results or previous mental health correspondence considered relevant.**

**SECTION 6 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 7 Medical, surgical and obstetric history**

**Alcohol Status/History:**

**Smoking Status/History:**

**Medical History:**

**Comorbidities:**

**Previous Procedures:**

**Allergies/Adverse Reactions:**

**Current prescribed medications:**

**SMOs/VMOs in this Specialist Service**

Dr Susan Roberts (Clinical Lead)