CABRINI WOMEN'S MENTAL HEALTH REFERRAL

2-6 Hopetoun St, Elsternwick VIC 3185 Ph: (03) 9508 5100 Email: wmh@cabrini.com.au

PATIENT DETAILS

Client's name: DOB:

Phone number: Aboriginal or Torres Strait Islander? ☐ Yes ☐ No

Email address:

Address:

Postcode:

Health fund details: Member number:

Medicare number: Exp. date:

Client's number on Medicare card:

NEXT OF KIN DETAILS

Name: Phone number:

Name: Phone number:

Relationship to client:

REFERRING PSYCHIATRIST/GP DETAILS

Name: Phone number:

Practice details:

Referrer signature:

REASON FOR ADMISSION

Has the patient been admitted to a private facility in the last seven days? ☐ Yes ☐ No

Details:

PAST HISTORY

- Psychiatric history (diagnoses, medications etc.)
- Medical history

ANY OTHER RELEVANT DETAILS

OFFICE USE ONLY

Date of initial contact:

Cabrini staff member receiving referral:

For any queries or referrals please contact:

Ph: (03) 9508 5100

Email: wmh@cabrini.com.au

Cabrini