

OLDER ADULT

Joondalup Older Adult
Regents Park Road
JOONDALUP 6027
Tel: 9400 9566
Fax: 9400 9518

Osborne Older Adult
Osborne Place
STIRLING 6021
Tel: 9346 8300
Fax: 9346 8388

Selby Older Adult
6 Lemnos St
Shenton Park 6008
Tel: 9382 0800
Fax: 9382 0820

ADULT MENTAL HEALTH

Avro Clinic
2 Nicholson Rd
SUBIACO 6008
Tel: 9381 9055
Fax: 9382 4171

Clarkson MHS
PO Box 2002
77 Renshaw Boulevard
CLARKSON 6030
Tel: 9404 0094
Fax: 9404 0099

Joondalup M.H.S
PO Box 382
JOONDALUP 6027
Tel: 9300 0369
Fax: 9300 3894

Mirraboooka M.H.S
U4/14 Chesterfield Rd
MIRRABOOKA 6061
Tel: 9344 5400
Fax: 9345 2631

Osborne Clinic
Osborne Place
STIRLING 6021
Tel: 9346 8350
Fax: 9346 8288

CHILD & ADOLESCENT M.H

Clarkson CAMHS
77 Renshaw Boulevard
CLARKSON 6030
Tel: 9304 6200
Fax: 9304 6199

Hillarys CAMHS
U2/3 Endeavour
Business Centre
32 Endeavour Rd
HILLARYS 6025
Tel: 9403 1999
Fax: 9401 1611

Warwick CAMHS
316 Erindale Rd
WARWICK 6024
Tel: 9448 5544
Fax: 9448 3281

Shenton CAMHS
227 Stubbs Tce
SHENTON PARK 6008
Tel: 9382 0773
Fax: 9382 0717

October 2004

**NORTH METROPOLITAN AREA HEALTH SERVICE
AREA MENTAL HEALTH SERVICE
REFERRAL FORM**



Referring Doctor: _____ Tel: _____

Patient: _____ DOB: _____ Sex: M / F

Address: _____ Tel: _____

Next of kin/Carer: _____ Relation to client: _____ Tel: _____

Services currently/previously involved: _____

Speaks English: Y / N Interpreter required?: Y / N Language spoken _____

CAMHS Number of siblings? _____ School: _____ Year: _____	ADULT Marital Status: _____ No. Dependant Children: _____ No. Children at Home: _____	OLDER ADULT Known to ACAT ? Y / N Veterans' Affairs ? Y / N Guardian? Y / N
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Reason for Referral: _____

Past Psychiatric History: _____
 / or Significant Family Issue (CAMHS) _____

Past Medical History: _____

Medications: _____

Urgency: Low Medium High

Current Risk Factors: *Suicidal ideation or behaviour* *Self-harm*
 Aggressive behaviours *Self-neglect or accident*
 Vulnerable to abuse/exploitation *Alcohol & other drug use*
 Wandering *Other* _____

Has the patient ever been in hospital because of psychiatric or psychological problems?
Yes / No When? _____ Where? _____

Has the patient ever received counselling or therapy:
Yes / No When? _____ Where? _____

Does the patient have a history of aggressive behaviour? Yes No

Other comments: _____

Signature of G.P.: _____ Date: _____