UnitingCare Health

Referral for Cooinda Mental Health Service

Family Name: _____ MR/UR: _____

Given names: _____

Address: _____

Postcode: _____ DOB: _____

Doctor: _____

(or place Patient ID Label here)

Please select:

❑ Inpatient Assessment/Admission

❑ Out Patient Day programs → Which Program: _____

If you choose: Transition to Wellness → Number of Days per week _____ and Length of referral _____

Patient's Name: .....

Phone number: (H) ..... (M) ..... (Email) .....

Next of Kin: ..... (Contact No.) .....

DVA number: ..... ❑gold ❑white

Private Health Fund: ..... Membership No.: .....

Medicare number: .....

GP Name: .....

GP Address: .....

Contact Details: (PH) ..... (Fax) .....

Level of Urgency ❑ Urgent ❑ Next availability

Current Diagnosis: .....

Primary Reason for Referral: .....

.....

Secondary Reason: .....

Current Known Risks: .....

.....

Current Treatment: .....

.....

Referred by VMP: ..... (PH) .....

Signature: ..... **Date:** .....

General Enquiries Phone: 1300 780 413

Forward to Cooinda Mental Health Service

Inpatient Fax: (07) 5452 0672 Outpatient Day Program Fax: (07) 5452 0671

Email:scph.cooinda@uchealth.com.au

Office Use Only:	Date Received:	By:
	Date forwarded to TSCPH Preadmissions Clinic:	
	Date forwarded to Intake:	Follow up Clinician:

Version: V1.30 October 2014

2.28

Referral for Cooinda Mental Health Service