Please use I.D. label or block print

FIONA STANLEY FREMANTLE HOSPITAL GROUP

COCKBURN HEALTH REFERRAL FORM

☐ Womens Mental Health
☐ AOD / Behavioural Management
☐ Eating Disorders

SURNAME	UMRN	
GIVEN NAMES	DOB	GENDER
ADDRESS		POSTCODE
	TELEPHONE	

REFERRER DETAILS

Service: ______________________ Contact Person: ______________________

Contact details: Phone: ______________________ Email: ______________________

IDENTIFIES AS	☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander	☐ Neither ☐ Prefer not to say ☐ Other ____________
INTERPRETER REQUIRED	☐ Yes ☐ No	Language spoken ____________
MARITAL STATUS	☐ Single ☐ Separated / Divorced	☐ Married / Defacto ☐ Widowed
LIVING SITUATION	☐ Family ☐ Alone ☐ Other ____________	☐ Friends ☐ Care home
DEPENDENTS	☐ Children (number of) ________	Ages of children ____________ ☐ Has children not in their care
EMPLOYMENT STATUS	☐ Employed ☐ Home Duties ☐ Unemployed	☐ Retired ☐ Other ☐ School ☐ Student

Private Health Insurance ☐ **Yes** ☐ **No** **Provider** ______________________

DETAILS OF SIGNIFICANT OTHER / NEXT OF KIN / CARER

Name: ______________________ Relationship: ______________________

Contact details: ______________________ To be involved in treatment Yes ☐ No ☐

Name: ______________________ Relationship: ______________________

Contact details: ______________________ To be involved in treatment Yes ☐ No ☐

Other Services / Supports Involved .i.e. GP, Psychology, NDIS
1. Reason and Aim of Referral

DO NOT WRITE IN MARGIN

COCKBURN HEALTH REFERRAL FORM

MR707

HCHFSFMR0707

FS1229
08/24

Please use I.D. label or block print

FIONA STANLEY FREMANTLE HOSPITAL GROUP	SURNAME	UMRN	
COCKBURN HEALTH REFERRAL FORM	GIVEN NAMES	DOB	GENDER
☐ Womens Mental Health ☐ AOD / Behavioural Management ☐ Eating Disorders	ADDRESS		POSTCODE
		TELEPHONE	

2. Current Mental State

3. Current Risk Factors

☐ Self harm ☐ Suicide ☐ Harm to others ☐ Physical Health ☐ Aggression / Violence ☐ FDV
☐ Forensic History ☐ Legal Issues ☐ Other

4. Previous History of risk

☐ Self harm ☐ Harm to others ☐ Physical Health ☐ Reputation ☐ Aggression / Violence
☐ FDV ☐ Forensic History ☐ Other

5. Mental Health History

6. Current and Relevant Medical History – Please attach completed relevant documentation

☐ ECG ☐ Bloods ☐ Physical Observations ☐ BSL ☐ BBV ☐ Known disabilities or impairments

7. Current Medications, Medication Reactions and Known Allergies – attach list

8. Anthropometry – FOR EATING DISORDER REFERRALS ONLY – Date recorded:

Height (cm): __________________ Weight (kg): __________________ BMI kgm2): __________________

Weight history:

9. Alcohol and Other Drug Use – Document Risk Factors e.g. seziures, OD, etc

10. Follow up Discharge Plan

CLIENT CONSENT TO REFERRAL ☐ Yes ☐ No

Permission from Guardian (if under 18 years) (ED only) ☐ Yes ☐ No

Date of referral: Time:

Email completed referral to:

Womens Mental Health	FSHCH.MHWMHTriage@health.wa.gov.au
Eating Disorders	FSHCH.MHEDTriage@health.wa.gov.au
AOD / Behavioural Management	FSHCH.MHAODBehaviourTriage@health.wa.gov.au

DO NOT WRITE IN MARGIN