NS 85

Metro-South Health Service District Division of Mental Health

REFERRAL TO TRANSCULTURAL CLINICAL CONSULTATION SERVICE

UR: _____

SURNAME: _____

GIVEN NAMES: _____

DATE OF BIRTH: _____

☐ MALE ☐ FEMALE

(Affix patient label here)

DATE OF REFERRAL _____

CLIENT DETAILS

Given names: _____ Surname: _____

Date of Birth: _____ Age: _____

Address: _____

Phone: _____ Mobile: _____

Country of Birth: _____ Date of arrival in Australia: _____

Ethnicity: _____ Religion: _____

Preferred Language(s): _____ Interpreter required: ☐ Yes ☐ No

Next of Kin (or parent/guardian if under 18 years)

Given names: _____ Surname: _____

Relationship to client: _____ Phone: _____

REFERRER DETAILS

Name of referrer: _____ Phone: _____

Organisation: _____

Address: _____

Name of GP: _____ Phone: _____

Address: _____

CONSENT

The client is aware of the referral and agrees to this referral being made ☐ Yes ☐ No

The client has signed the TCCS consent form and it is attached with this referral ☐ Yes ☐ No

(If the client has difficulties signing the consent form please discuss this with the TCCS intake officer)

Print Form

REFERRAL TO TRANSCULTURAL CLINICAL CONSULTATION SERVICE

NS 85

Metro-South Health Service District Division of Mental Health

REFERRAL TO TRANSCULTURAL CLINICAL CONSULTATION SERVICE

UR: _____

SURNAME: _____

GIVEN NAMES: _____

DATE OF BIRTH: _____

☐ MALE ☐ FEMALE

(Affix patient label here)

HEALTH INFORMATION

Physical health concerns:

Mental health concerns:

Status under the Mental Health Act:

☐ Voluntary

☐ Involuntary Please state what type of order _____

Medication:

DETAILS ABOUT THE CLIENT'S FAMILY (please include details of family or family genogram)

Print Form

REFERRAL TO TRANSCULTURAL CLINICAL CONSULTATION SERVICE

NS 85

Metro-South Health Service District Division of Mental Health

REFERRAL TO TRANSCULTURAL CLINICAL CONSULTATION SERVICE

UR: _____

SURNAME: _____

GIVEN NAMES: _____

DATE OF BIRTH: _____

☐ MALE ☐ FEMALE

(Affix patient label here)

WHAT ARE YOUR CURRENT CONCERNS FOR THE CLIENT

WHAT ASSISTANCE DO YOU REQUIRE FROM TCCS

BACKGROUND INFORMATION (Please attach assessment notes, reports or relevant information)

(Please feel free to use additional pages as required)

Once completed please fax to: The Intake Officer - Transcultural Clinical Consultation Service (07) 3317 1299

Print Form

REFERRAL TO TRANSCULTURAL CLINICAL CONSULTATION SERVICE