Melbourne Neuropsychiatry Centre
www.neuropsychiatry..org.au

NEUROPSYCHIATRY UNIT REFERRAL FORM

ATTN: NEUROPSYCHIATRY REGISTRAR FAX: 03 93428483

Department of Neuropsychiatry Level 2, John Cade Building
Royal Melbourne Hospital 3050
T: 03 93428750

NorthWestern Mental Health

Inner West Area Mental Health Service – The Royal Melbourne Hospital

Inner West Area Mental Health Service is a provider of services to the Royal Melbourne Hospital

www.mh.org.au
ABN 73 802 706 792

REFERRER DETAILS

DATE: ___ / _____ / _____

Name _____
_____
_____
_____

Address _____
_____
_____P/CODE_____

Phone: (___)_____
Fax: (___)_____
Email: _____@_____

- ☐ **Psychiatry** - ☐ **Area Mental Health** ☐ **Private**
- ☐ **Neurology** - ☐ **General Hospital** ☐ **Private/Community**
- ☐ **Medical/Surgical** - ☐ **General Hospital** ☐ **Private/Community**
- ☐ **General Practitioner**
- ☐ **Other Service/Agency**_____

PATIENT DETAILS

Surname _____
First Name _____

Gender ☐ **Male** ☐ **Female**
DOB ____/_____/_____

Address_____
_____
_____
_____P/CODE_____

Telephone _____ **Mobile** _____
Contact Person _____

☐ **URBAN** ☐ **RURAL**

REFERRAL URGENCY:

☐ **< 1 week** ☐ **1-4 weeks** ☐ **> 4 weeks**

REFERRAL CHECKLIST- ALL REQUIRED

- ☐ **Referral letter- summarising patients problem list and referral question**
- ☐ **Other reports/ summaries/ relevant correspondence**
- ☐ **Investigation results - biochemical, imaging**
- ☐ **Neuroimaging (MRI) on CD and mailed**
- ☐ **Patient/ carer accepting of referral**

REFERRAL REASONS

- ☐ **Cognitive Impairment**
- ☐ **Psychotic Disorder**
- ☐ **Affective Disorder**
- ☐ **Functional/Behavioural Change**
- ☐ **Movement Disorder**
- ☐ **Neurological Disorder**
- ☐ **Other** _____

ASSESSMENT TYPE

☐ **Inpatient** ☐ **General Outpatients**

SPECIFIC SERVICE

- ☐ **HD Clinic** ☐ **Predictive HD Clinic**
- ☐ **Epilepsy** ☐ **Psychosurgery Assessment**
- ☐ **ECT**
- ☐ **Younger Onset Dementia**

NEUROPSYCHIATRY UNIT USE ONLY

Referrer contacted ☐ **Y** ☐ **N** **Clinician responsible** _____

CRM:
ASSESSMENT DATE ___/____/____
DOCTOR _____

- ☐ **Inpatient Waiting List** IPWL
- ☐ **Outpatient Neuropsychiatry** ☐ **Public** OPC
- ☐ **HD Predictive Clinic** OPCHDP ☐ **Private** ☐ **RMH OPP** ☐ **MW** MWPRIV
- ☐ **HD Symptomatic Clinic** OPCHDS ☐ **TMC** ☐ **DV** DVPRIV
- ☐ **Outpatient Neuropsychology** OPN
- ☐ **Off-Site Assessment** OSA
- ☐ **Consultation-Liaison Assessment** CL
- ☐ **Referral Not Accepted** ☐ **Not Neuropsychiatric** RNANP
  ☐ **Other Service More Appropriate** RNAOTH
- ☐ **Referral Withdrawn** ☐ **By Patient/Relative** RWP
  ☐ **By Referrer** RWP
- ☐ **Phone Advice** PA