REFERRAL FAX TO TOWN HILL HOSPITAL – 033 3455720

Receiving Dr.: _____

Surname: _____ **First Name:** _____ **DOB:** _____

Age: _____ **ID No.:** _____ **Sex:** _____ **Marital Status:** _____

Address: _____

Names & contact details of family: _____

Referral Source: _____ **Tel. No.:** _____ **Fax:** _____

Ward: _____ **Date of Admission to your hospital:** _____

Presentation & reasons for admission to your hospital: _____

_____

_____

_____

_____

_____

Past Psychiatric history: _____

_____

_____

_____

_____

_____

Past & current medical history: _____

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_____

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_____

Current medications (including all trials of meds): _____

_____

_____

_____

Current physical examination: _____

_____

_____

_____

_____

Current MSE: _____

_____

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_____

Results of Investigations: _____

_____

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_____

Reason for referral: _____

_____

_____

_____

_____

Doctors Name (Printed legibly): _____ **Signature:** _____

Drs Tel. No.: _____ **Cell:** _____ **Date:** _____

P.S. Are all forms filled in BLACK ink and filled in correctly and fully? Is the inpatient referral form filled in fully? CHECKLIST: MHCA 04 with commissioner of oath stamp.
MHCA 05 X 2, MHCA 06, MHCA 07, 08, 11 with correct dates.
Has patient been assessed by a Psychiatrist at your hospital? YES: Dr. _____ NO.