REFERRAL FORM TO PSYCHIATRIC OPD CLINIC.
(for MEDICAL PRACTITIONERS)

NAME: ______________________________ **DOB:** ________________ **GENDER: M / F**
ID No.: ____________________________ **MARITAL STATUS:** ________________________
ADDRESS: ____
TEL. No.: (H): _________________________ **(W):** ________________ **CELL:** ________________
OCCUPATION: _________________________ **LEVEL OF EDUCATION:** ________________
FAMILY / FRIEND NAME: _______________________ **RELATIONSHIP:** ________________
ADDRESS: ____
CONTACT No.: (H): ____________________ **(W):** ________________ **CELL:** ________________
REFERRAL SOURCE: ____
CONTACT DETAILS OF SOURCE: ____
DATE OF REFERRAL: ________________________ **DATE CONSULTED:** ________________

REASONS FOR REFERRAL:

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SUMMARY OF CURRENT PRESENTATION:

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PAST PSYCHIATRIC HISTORY:

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PAST MEDICAL & SURGICAL HISTORY: ***(including traumatic brain injury, epilepsy, etc.)***

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FAMILY HISTORY: ***(including mental illness, chronic medical conditions, suicide, etc.)***

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PERSONAL HISTORY: ***(including birth, development, academic, occupational, military, marital, sexual, forensic and cultural history, etc.)***

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SUBSTANCE USE, ABUSE OR DEPENDENCE: ***(including OTC's, rehab. admissions, etc.)***

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PHYSICAL EXAMINATION:

VITAL SIGNS:	**BP:**	**PR:**	**TEMP:**	**RR:**
LOC / GCS:				
INJURIES:				
CVS:				
RS:				
ABD:				
CNS:				

MENTAL STATE EXAMINATION: ***(Tick appropriate boxes)***

Appearance:	**Unkempt**		**Neat, tidy**		**Garish**	
Activity:	**Retarded**		**Normal**		**Hyperactive**	
Attitude:	**Hostile, aggressive**		**Co-operative**		**Non-responsive**	
Speech:	**Pressured**		**Normal**		**Retarded**	
Thought form:	**Flight of ideas**		**Normal**		**Disordered**	
Thought content:	**Deluded**		**Normal**		**Poverty**	
Perceptual disturbances:	**Auditory hallucinations**		**Visual hallucinations**		**Other hallucinations**	
Mood:	**Elevated**		**Normal**		**Depressed**	
Affect:	**Restricted**		**Normal, reactive**		**Flat**	
Sleep:	**Insomnia**		**Normal**		**Hypersomnia**	
Appetite:	**Loss**		**Normal**		**Hyperphagia**	

Energy:	Increased		Normal		Decreased	
Orientation:	Time		Person		Place	
Attention & concentration:	Distractible, hypervigilant		Intact		Decreased, hypovigilant	
Memory:	Immediate		Recent		Remote	
Insight:	Nil		Partial, superficial		Full	
Judgement:	Coarse		Intact		Poor	
Suicide:	Ideation		Nil		Has plan	
Homicide:	Ideation		Nil		Has plan	

SPECIAL INVESTIGATIONS: ***(include type, date and results; where possible ATTACH COPIES)***

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WORKING DIAGNOSIS:

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CURRENT PSYCHIATRIC TREATMENT: ***(include response, adverse effects and any psychotherapy, etc)***

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CURRENT MEDICAL TREATMENT*:* ***(include names, dose and response, as well as adverse effects, etc.)***

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NAME (print legibly): ______________________________ SIGNATURE: __________________________
DATE: ________________________________