Government of **Western Australia**
WA Country Health Service

Midwest Mental Health & Community Alcohol and Drug Service Referral Form

PO Box 22 Geraldton WA 6531
Phone: 1800 051 999 Fax: 9956 1998
WACHS-Midwest.MMH&CADSReception@health.wa.gov.au

IDENTIFY

Referral date:		Mental Health	☐	Community Alcohol and Drug	☐
Patient Details:					
Surname:		Given names:			
Date of Birth:		Gender:			
Ethnicity:		Medicare No:			
Address:		Phone:			
		Email/Other			
Parent / Guardian / Personal Support Details:					
Name:					
Address:		Phone:			
		Email/Other:			
Referred By:					
Name:		Agency:			
Address:		Phone:			
		Fax:			
Email:					

SITUATION

Presenting Mental Health / Drug or Alcohol problem / Reason for Referral: Specify MMH&CADS program if known

OBSERVATION

Current Functioning: Thoughts, feelings, social / domestic functioning:

Risk Factors: Harm to self, harm to others, vulnerability or impaired decision making:

BACKGROUND

Other Factors: Accommodation, legal, financial, employment, education, relationships, family:

Mental Health / Drug or Alcohol History: Diagnoses, duration, severity, previous treatments, interventions:

General Medical History: Allergies, alerts, comorbidities, recent investigation findings:

Medications: All current	Dosage	Comments

Any recently ceased:

Additional Reports Attached: (physical health summary, medication list, medical tests and bloods, school reports, psychological reports, other)

Please Tick ☐

AGREE A PLAN

Has patient / guardian agreed to this referral?	Yes ☐	No ☐
Has patient / guardian received Crisis support numbers?	Yes ☐	No ☐

READ BACK

MMH&CADS Checklist

Received date:		ACCESS clinician:			
Referral received by: Email ☐ Fax ☐ Phone ☐ Mail ☐		CTRS date:		CTRS:	
Choice Clinician:		Date Referrer informed of outcome:			
UMRN:		PSOLIS No:		SIMS No	