



DATE:

GP REFERRAL TO:

Townsville Integrated Mental Health Services

Kirwan Health Campus

138 Thuringowa Drive

KIRWAN QLD 4817

Phone: (07) 47 999 480

Facsimile (07) 47 999 506

REFERRED BY:

Name:

Practice:

Telephone:

Facsimile

Address

PATIENT DETAILS

Surname:

First Name:

DOB:

Home Address:

Telephone (Home):

(Mobile):

REASON FOR REFERRAL: (Relevant History & Current Stressors)

MENTAL STATE: (Appearance, Mood, Thought Content, Orientation)

CURRENT MEDICATION:

RISK OF SELF HARM:

Low Medium High

RISK OF HARM TO OTHERS:

Low Medium High

SUBSTANCE USE:

Yes No Unsure

Specify:

If main problem is related to:

Substance Use: please refer to *ATODS 4778 9677*

Relationship Problems: please refer to *Relationships Australia 4771 3780*

Counselling: please consider referral to *Better Outcomes /Access*

Domestic Violence / Sexual Assault: please consider referral to the *Womens Centre 4775 7555*

SIGNED: _____ **DATE:** _____