Please Fax/E mail Referral as first step and ask your patient to expect a call back for triage/appointment

Bibra Lake
Specialist Centre

Fax: 9417 3270
Tel: 9414 7860

10/14 Annois Road,
Bibra Lake, WA 6163

REFERRAL FORM

ABOUT THE CLIENT:

Surname:_____ **First/Given Names:**_____
Gender: ◉**M** ○**F** **Date of Birth:**_____ **Medicare No:**_____
Phone (H):_____ **(M)**_____
Address (Current):_____
Next of Kin and contact details: _____
Medical History: _____
Current Medication:_____

_____

_____

Allergies: _____

REFERRAL ISSUES (tick as appropriate):

Depression ☐	Somatic s/s ☐	Impulsivity ☐	Issues with Alcohol ☐ THC ☐ Stimulants ☐ Benzo's ☐ Opioids ☐ Other ☐	ADHD/Eating Disorder- **PLEASE REFER ELSEWHERE** ☐
Anxiety ☐ OCD ☐ PTSD ☐	Mania ☐	Socially withdrawn ☐		
Psychosis ☐	Daily mood fluctuations ☐	Interpersonal Issues ☐		

1) **Please elaborate (if required)**

_____

2) **Second opinion:**_____
Previous or current psychiatrist or psychologist:_____
Previous Diagnosis (if known):_____
3) **Ongoing management (any specific issues):**_____
4) **Risk issues (acutely suicidal clients need referral to MHERL/ED):**_____
5) **History of aggressive or assaultive behaviour:**_____
6) **Forensic/legal matters known:**_____

Referrer's Name:_____
Provider Number:_____
Date of referral:_____
Contact Details:_____
Prefered correspondence: ☐ **By Post** ☐ **Email**_____

As much as it is an endeavor to provide professional psychiatric care, not every referred patient may be accepted
Non urgent out patient service only
For crisis please contact 1300 555 788 or attend nearest Emergency

Gap Fee Applicable- NO BULK BILLING
Failure to attend or cancel appointment 48 hours in advance would incur a fee (unless medical emergency)

Save and Email to reception@blsc.net.au