REFERRAL FOR MBS ITEM 291
BOOKED PSYCHIATRIC ASSESSMENT – NON-URGENT

Fax with copy of GP Mental Health Plan if possible (Item 2710 /2702) to: (08) 7425 8608 or email to Health.SCMHSAdmin@sa.gov.au

Telephone: (08) 7425 8505

Date:

To:

☐ Dr Albert Matti	☐ Dr Titus Mohan	☐ Dr Rohan Dhillon
☐ Dr Devinda Lecamwasam	☐ Dr Tushar Singh	☐ Dr Arun Gupta
☐ Dr Sarath Attanayake	☐ Dr Tarun Bastiampillai	☐ Dr Vineet Juneja
☐ Dr Devon Marshman	☐ Dr Rose Neild	☐ Next Available

Re: Name:
Address:

Telephone: Home: Mobile:
DOB:
Medicare No:

As we are a non-urgent MH service, level of risk will determine if your patient is appropriate for our service. If no level of risk is selected, this may cause a delay in scheduling an appointment.

RISK: ☐ Low ☐ Moderate ☐ High

Reason for Referral: *(Please give us as much relevant information as possible)*

Past History: *(Please include: any relevant family, social or forensic history)*

Medications:

Employment:

Assessment suitability criteria (must complete this section)

Require assessment for 3rd party?	☐ No	Attention Deficit Disorder?	☐ No
Will you be responsible for continuing care of the patient?	☐ Yes	Intellectual Disability? ASD?	☐ No ☐ No
Is a one-off assessment and management plan appropriate support for the care of your patient?	☐ Yes	Is your patient in a crisis situation?	☐ No

If Criteria is not met: Consider referral to a private psychiatrist. Contact Mental Health Triage if in a crisis situation or risk is high, as well as for advice on referring to a Community Mental Health Team and if appropriate.

Additional Comments:

Patient agrees to this referral? ☐ Yes ☐ No

Patients signature: _____

Regards,

Doctor: *(Please tick if regular GP?)* ☐
Provider Number:
Practice:
Address: Postcode:
Telephone:
Fax Number:

Doctors signature: _____