Government of South Australia
SA Health

Rural and Remote Mental Health Service

REFERRAL FOR TELEPSYCHIATRY ASSESSMENT

**** = Required Information: Please ensure on the referral all areas are filled out in detail including the GP's signature.***

* DATE OF REFERRAL: _____ * PATIENT NAME: _____

* ADDRESSS: _____ *Male/Female_____

NATIONALITY:_____ DOB: _____ * INDIGENOUS / ATSI: Y / N

* TELEPHONE: * MEDICARE NO: * M/C CARD REFERENCE NO:

Attention:
The Consulting Psychiatrist
Rural and Remote Mental Health Service,
Telepsychiatry Service

AGES 16-64yrs
Ph.: (08) 7087 1660
Fax: (08) 7087 1630

AGES 65+ yrs.
Ph: (08) 7087 1650
Fax: (08) 7087 1630

PLEASE SELECT AGE GROUP ABOVE

*Could this assessment be arranged with a visiting/local Psychiatrist? Y / N
*Does the patient require an interpreter? Y / N
*Has the GP initiated this referral? Y / N

* **For people aged 65 years and over**,

1. The letter should include psychiatric and physical health history, medication record, blood results (blood screen, electrolytes, renal and liver function, Ca, Thyroid hormones, B12 and folate), and urine C&S. Please attach CT head and chest X-ray results if available.
2. A Mini-Mental State Examination needs to be attached.

Services that **will not** be covered by RRMHS Telepsychiatry Service

- Forensic Assessments
- Medico Legal Reports
- Work Cover Reports
- Adult ADHD Assessments

*** CURRENT PROBLEM: (**Diagnosis; current stressors; current symptoms; safety issues; other issues of importance)

*** PAST PSYCHIATRIC /MEDICAL/PERSONAL HISTORY OF NOTE:**
(Including previous Telepsychiatry, contact with visiting or private Psychiatrist)

*** CURRENT MEDICATION:** (including dose and any adverse effects) If more space required please use additional sheet

ALLERGIES:

PREVIOUS MEDICATION TRIALS (for Mental Health Issues): (if known)
(alternatively a print out of a medication summary would suffice)

*** IF INPATIENT:–** (Name of facility, precipitants / triggers for admission)

*** OTHER SERVICES INVOLVED**

DESIRED OUTCOMES / ISSUES REQUIRING SPECIFIC ATTENTION:
In order to maximise use of the session, please expand on the areas to be focussed on such as:

- *Any necessary changes in management for the patient / Need for medication change*
- *How the local CMHT & GP can support the patient How the telepsychiatry service can support the local treating team & GP*
- *Recommendations for biological, psychological or social management*

REFERRED BY (please include signature – as appropriate):

* GP Name:	Dr	* Phone:		Fax:	
* GP Signature:				* Provider No:	
* Clinician Name:		* Phone:		Fax:	
* Clinician Signature:					
* Name of referring person:				Referral Valid for 12 months □ or Indefinite □	

FEEDBACK MECHANISM *(tick as required)*

Feedback to: **GP** **MHW** **OTHER** (specify)

☐ Phone immediately following session

☐ Fax written report ASAP following session

Notes: