ST JOHN OF GOD
Pinelodge Clinic

Tel.: 1800 939 444
Fax: 8793 9335
Address: 1480 Heatherton Road, Dandenong 3175
Email: access.pinelodgeclinic@sjog.org.au

REFERRAL

Referring Doctor

Name: ____________________

Address: ____________________

____

Tel.: ____________________

Provider No.: ____________________

Signature: Date:

Patient Information

Surname: ____________________

Given Names: ____________________

D.O.B: ____________________

Tel.: ____________________

Address:

UR: (office use only)

If the person is under 18, please provide legal guardian details:

Guardian Name: ____________________ Relationship to child: ____________________

Guardian Address: ____________________

____________________ Guardian Telephone: ____________________

Does this person have private health insurance? Yes ☐ No ☐ Unsure ☐

Health Fund details: ____________________

Membership number: ____________________

Is this person: WorkCover ☐ TAC ☐ Other ☐ ____________________

Referral for:

☐ Current patient ☐ Ex-patient ☐ New patient

- ☐ Inpatient Admission
- ☐ Group Based Therapy Day Programs
- ☐ Outpatient Psychiatry
- ☐ Outpatient Psychology Clinic
  Mental Health Plan: Yes ☐ No ☐ (6 sessions)
- ☐ Inpatient 1:1
- ☐ Community Mental Health Services

If current patient, estimated discharge date: ____________________

In what timeframe would you like the person to be seen: Within 1 week ☐ 1-2 weeks ☐ ASAP ☐

Current Medication:

Please ensure all sections on both sides are completed

BRIEF HISTORY AND REASON FOR REFERRAL:

RISKS:

Aggression to Others:	High	☐	Moderate	☐	Low	☐	Details:
Aggression from Others:	High	☐	Moderate	☐	Low	☐	Details:
Self Harm/Suicide:	High	☐	Moderate	☐	Low	☐	Details:
Sexual Disinhibition:	High	☐	Moderate	☐	Low	☐	Details:
Physical Neglect:	High	☐	Moderate	☐	Low	☐	Details:
Substance Abuse:	High	☐	Moderate	☐	Low	☐	Details:
Environmental Risk:	High	☐	Moderate	☐	Low	☐	Details:

Other: ______________________________

RELEVANT MEDICAL HISTORY: (please include any Investigation or Pathology results)

PATIENTS GP: ______________________________

Telephone No. ____________________ Address: ____________________

Other services involved: Yes ☐ No ☐

______________________________ Telephone: ____________________

______________________________ Telephone: ____________________

Hospital Administration Use: Health fund checked: ☐ Assessment booked ☐

Current PLC programs: ______________________________

Previous Inpatient discharge date: ______________________________

Name: Signature: Date:

Please ensure all sections on both sides are completed