NorthWestern Mental Health

Melbourne Neuropsychiatry Centre
www.neuropsychiatry..org.au

Inner West Area Mental Health Service – The Royal Melbourne Hospital

Inner West Area Mental Health Service is a provider of services to the Royal Melbourne Hospital

www.mh.org.au
ABN 73 802 706 792

# Neuropsychiatry Unit Referral Form

**Department of Neuropsychiatry Registrar**
**Level 2, John Cade Building**
**Royal Melbourne Hospital 3050 T: 03 9342 8750**

| ATTACH LABEL OR RECORD PATIENT DETAILS | | |
|---|---|---|
| LOCAL UR | MH UR | |
| NAME | | |
| ADDRESS | | |
| TELEPHONE | DOB | SEX M/F |

NWMH312

## ATTENTION: NEUROPSYCHIATRY REGISTRAR FAX: 03 9342 8483

**REFERRER DETAILS:** **DATE: / /**

**Name** _____
**Address** _____
***Mobile No** _____
**Fax: ( )** _____
***Email:** _____

- ☐ **Psychiatry -** ☐ **Area Mental Health**
- ☐ **Neurology -** ☐ **General Hospital**
- ☐ **Medical/Surgical –** ☐ **General Hospital**
- ☐ **General Practitioner**
- ☐ **Other Service/Agency**

***To ensure prompt response, please provide direct contact details**

**PATIENT DETAILS**

**Surname** _____
**First Name**
**Gender** ☐ Male ☐ Female
**DOB** / /
**Address**
Postcode
**Telephone**
**Contact Person**
☐ **URBAN** ☐ **RURAL**

**REFERRAL URGENCY**
☐ **<1 week** ☐ **1-4 weeks** ☐ **>4 weeks**

**REFERRAL CHECKLIST – ALL REQUIRED**
- ☐ **Referral letter – summarising patient's problem list and referral question**
- ☐ **Other reports/summaries/relevant correspondence**
- ☐ **Investigation results – biochemical, imaging**
- ☐ **Neuroimaging (MRI) on CD and mailed**
- ☐ **Patient / carer accepting of referral**

**REFERRAL REASON**
- ☐ **Cognitive Impairment**
- ☐ **Psychotic Disorder**
- ☐ **Affective Disorder**
- ☐ **Functional / Behavioural Change**
- ☐ **Movement Disorder**
- ☐ **Neurological Disorder**
- ☐ **Other**

**ASSESSMENT TYPE**
- ☐ **Inpatient** ☐ **General Outpatients**
- ☐ **Telehealth** ☐ **BCV**

**SPECIFIC SERVICE**
- ☐ **HD Clinic** ☐ **Predictive HD Clinic**
- ☐ **Epilepsy** ☐ **Psychosurgery Assessment**
- ☐ **ECT**
- ☐ **Younger Onset Dementia**

**NEUROPSYCHIATRY UNIT USE ONLY**

**Referrer contacted** ☐ **Y** ☐ **N** **Clinician responsible**

**ASSESSMENT DATE** /

**DOCTOR:** _____

☐ **Inpatient Waiting List** IPWL

- ☐ **Outpatient Neuropsychiatry**
- ☐ **HD Predictive Clinic** OPCHDP
- ☐ **HD Symptomatic Clinic** OPCHDS
- ☐ **Outpatient Neuropsychology** OPN
- ☐ **Off Site Assessment** OSA
- ☐ **Consultation Liaison Assessment** CL

☐ **Public** OPC
☐ **Private** ☐ **RMH OPP** ☐ **MW** MWPRIV ☐ **TMC** ☐ **DV** DVPRIV

- ☐ **Referral Not Accept** ☐ **Not Neuropsychiatric** RNANP ☐ **Other Service More Appropriate**
- ☐ **Referral Withdrawn** ☐ **By Patient/Relative** RWP ☐ **By Referrer** RWP
- ☐ **Phone Advice** PA

**NEUROPSYCHIATRY UNIT REFERRAL FORM**

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## FURTHER ACTION/COMMENTS

| Date | Action | Who |
|---|---|---|
| | | |