Adelaide Paediatrics

REFERRAL FOR MBS ITEM 291 PSYCHIATRIC ASSESSMENT NON-URGENT

Date:

To: Child & Adolescent Psychiatrist

Re: Name:
Address:

Telephone: (Home): (Mobile):
DOB:
Medicare No:

This service refers to a non-urgent assessment. You may need to access CAMHS services if requesting an urgent assessment on CAMHS Connect on 1300 222 647 for patients under 16 years of age.

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:

School:

Assessment suitability criteria (please complete this section)

Require assessment for 3rd party? (Court, Work Cover)	☐ Yes	☐ No
Will you be responsible for continuing care of the patient?	☐ Yes	☐ No
Is a one-off assessment and management plan appropriate support for the care of your patient?	☐ Yes	☐ No
Is your patient in a crisis situation?	☐ Yes	☐ 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

Regards,

Doctor: *(Please tick if Regular GP?)* ☐

Provider Number:

Practice:

Address: Postcode:

Telephone:

Please fax to (08) 7123 0821 and/or Email: bedford@adelaidepaediatrics.com.au

Please note that the assessment can also be completed via video link