Ramsay Cairns
Part of Ramsay Health Care

Mental Health Day Program Referral form

URNo: _____

Surname:_____

Given Name: _____

D.O.B:_____Sex: ☐ M ☐ F ☐ _____

(Affix Patient Identification label here)

1. Patient and Referring Doctor details

Patient title:_____ Surname:_____ Given names:_____

DOB:____/____/____ Contact Number: (H)_____(M)_____

Address:_____

Suburb:_____Postcode:_____

Private: Health Fund Name:_____Member Number:_____

Veteran: Card Type ☐ Gold ☐ White Card Number:_____

Workcover: Claim Number:_____

Uninsured: Patient has been informed of own financial obligations ☐ Yes ☐ No

Referring Doctor:_____Provider no:_____

Consulting rooms:_____Contact no:_____

Signature/stamp:_____

2. Referral Details

Diagnosis:_____

I wish to refer the above name patient to the following Day Program/s (Select one or more groups)

☐ Managing Mood Using Art Therapy 20 week program (half day)

☐ Managing Mood Using Dialectical Behavioural Therapy (DBT) 18 week program (full day)

☐ Managing Anxiety 24 week program (half day)

☐ Managing Mood Disorders 20 week program (half day)

☐ Relapse Prevention: Addictions/Drug & Alcohol (half day)

Additional Clinical Information / Special Needs:_____

3. Ramsay Clinic Cairns – Day Program Referral (for completion by RCC staff)

Upon receipt of this referral form, a member of Ramsay Clinic Cairns staff will contact your patient to process the referral and inform them of commencement date and if any payment is required.

RCC Group Facilitators Comments and Allocation:_____

_____

Start Date:_____Facilitator:_____Signature:_____

Email completed form: reception.tcc@ramsayhealth.com.au

Ramsay Clinic Cairns Phone No: 07 40507000 Fax No: 07 40507001

DAY PROGRAMS – REFERRAL FORM MR3.11