Ramsay Clinic
Cairns

'Setting the standards in mental health care'

RAMSAY CLINIC CAIRNS
GP/PSYCHIATRIST REFERRAL PAD

Intake Coordinator is available between 8am to 5pm Monday-Friday
Tel: 07 4050 7000 Fax: 07 4050 7001

The Intake Coordinator will receive all referrals, Liaise with Psychiatrists and GPs prior to contacting the patient.

The Intake Coordinator will liaise with the patient regarding admission when an appropriate bed/program start dates are available.

The Intake coordinator can send out any information/promotional material as requested.

Ramsay Clinic Cairns is unable to admit patients who are currently under the Mental Health Act.

RAMSAY CLINIC CAIRNS
253 Sheridan Street, Cairns QLD 4870
Phone: (07) 4050 7000 Fax: (07) 4050 7001
ramsay**mentalhealth**.com.au

Version 3.0 November 2021

GP / PSYCHIATRIST REFERRL FORM

Ramsay Clinic
Cairns

'Setting the standards in mental health care'

253 Sheridan Street, Cairns QLD 4870
Phone: (07) 4050 7000   Fax: (07) 4050 7001

Name:

DOB:

AFFIX PATIENT IDENTIFICATION LABEL

UR No: **DVA No:**

GP/Psychiatrist Referral Form

To be completed by Doctor. Please PRINT clearly.

1. Patient's Details

Title: ________ Surname: ____________________ Given Name: ____________________

Address: ____________________

Suburb: ____________________ Post Code: __________ DOB: __________

Home Phone: ____________________ Mobile/Business Phone: ____________________

Medicare No: ____________________ Ref: __________ Exp: __________

Health Insurance Provider: ____________________ Policy No: ____________________

2. Clinical Details / Reason for Referral

Inpatient Admission: ☐ Psychiatric ☐ Alcohol & Drug

Admission Urgency: ☐ Crisis ☐ Urgent ☐ Elective

Day Patient Programs: ☐ Drug & Alcohol Relapse Prevention ☐ Life Esteem ☐ PTSD
☐ Depression/Anxiety (CBT) ☐ DBT ☐ Bipolar Management

Provisional Diagnosis:

Presenting Symptoms:

Management Plan / Expected Length of Stay / Discharge Plan:

Other conditions / Special Needs:

3. Risk Screening

Patient Observation Category ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Specialling)

Suicide:	☐ High	☐ Moderate	☐ Low
Self Harm:	☐ High	☐ Moderate	☐ Low
Absconding:	☐ High	☐ Moderate	☐ Low
Aggression:	☐ High	☐ Moderate	☐ Low
Substance / Alcohol Use:	☐ High	☐ Moderate	☐ Low

4. Referring Doctor Details – or stamp

Name: ____________________ Provider No: ____________________

Address: ____________________ Phone: ____________________

Signature: ____________________ Date: ____________________

BINDING MARGIN - DO NOT WRITE

GP / PSYCHIATRIST REFERRL FORM