Day Program Services Referral Form

PLEASE INDICATE PROGRAM REQUIRED:	
General Outpatient Program	Drug and Alcohol Services
PATIENT INFORMATION:	
Full name:	Contact number:
PRIMARY DIAGNOSIS (AND SECONDARY IF APPLICABLE):	
Additional Information:	
AREAS REQUIRING ATTENTION:	
Unhelpful thinking patterns	Trauma, self-worth, and identity
Stress, anxiety, or low mood	Behavioural activation / motivation

AUTHORISATION AND REFERRER DETAILS

Mindfulness and acceptance skills

Relationships and communication

Routine, organisation, and focus

Emotional regulation and distress tolerance

By signing and sending this referral I declare and acknowledge that:

- This referral will be valid for 12 months.
- The information provided in this form is complete, true and correct to the best of my knowledge.
- The patient is suitable to safely engage in Ramsay Day Clinic Kahlyn outpatient programs.
- · The patient has consented to their personal and health information being shared with Ramsay Day Clinic Kahlyn.
- The referrer agrees to act as the treating psychiatrist for this patient throughout the referral period and will provide notification should this arrangement change.

Referrer name:

Phone number:

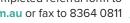
Email:

Signature:

Date:

Creative and expressive support (art, music)

Please email your completed referral form to admin.kph@ramsayhealth.com.au or fax to 8364 0811



Other

If other, please state:



40 Briant Road, Magill, SA 5072

Email: admin.kph@ramsayhealth.com.au

Phone: (08) 0130 4700

ramsaymentalhealth.com.au

People caring for people

