Ramsay Day Clinic Kahlyn

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
☐ Emotional regulation and distress tolerance	☐ Creative and expressive support (art, music)
☐ Mindfulness and acceptance skills	☐ Other If other, please state:
☐ Relationships and communication	
☐ Routine, organisation, and focus	

AUTHORISATION AND REFERRER DETAILS	
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.	Referring Psychiatrist: Phone number: Email: Signature: Date:

RESET FORM

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

SUBMIT FORM VIA EMAIL

MR0057007 RCAd Referral Form U 0226

Ramsay Day Clinic Kahlyn
40 Briant Road, Magill, SA 5072
Email: admin.kph@ramsayhealth.com.au
Phone: (08) 8130 4700
ramsaymentalhealth.com.au
People caring for people

Ramsay Mental Health