Bethesda Clinic Referral Form

for adult mental health admissions

This form is for Inpatient and Wellness Centre Only

Patient Information:			
Name: _____ Phone: _____			
D.O.B: _____ Email: _____			
Address: _____ Post Code: _____			
Health Fund: ☐ Private Health Fund ☐ DVA ☐ Workers Compensation ☐ Self-funded			
Membership No: _____ Excess/Co Pay: _____ Previous Bethesda Clinic Patient: ☐ Yes ☐ No			
Referrer Information:			
Referrers title: _____ Provider Number: _____ Phone Number: _____			
Details: _____ Email: _____			
Reason for Referral: Inpatient			
☐ Mental Health Stabilisation	☐ Risk Containment	☐ Medication Rationalisation	
☐ ECT	☐ Group Therapy		
Ward Required:			
☐ Women Only	☐ For Those Who Serve	☐ Alcohol and Other Drugs	☐ General Psychiatry
Reason for Referral: Wellness and Recovery Centre			
☐ Trauma Recovery (Military and First Responders)	☐ Alcohol and Other Drugs	☐ DBT	☐ Mood & Anxiety
Recent history, diagnosis, additional details (please attach any relevant documentations):			
Current Medications:			

Mandatory Safe Assessment:	**Date Completed:** _____	
	Historical	**Current**
Suicide Attempts or Self-harm: ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Legal Action Past / Pending: ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
History of Violence: ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Substance Abuse: ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Recent Fall: ☐ Yes ☐ No Ambulant: ☐ Yes ☐ No Independent: ☐ Yes ☐ No Continent: ☐ Yes ☐ No		

Bethesda Clinic | 1 Honour Way, Cockburn WA 6164 | bethesdaclinic.org.au
Ph: 08 6378 4900 | Triage: 08 6378 4999 BC.Triage@bethesda.org.au | Fax: 08 6378 4988

Bethesda clinic

Submit to BC.Triage@bethesda.org.au