# 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

**Submit to BC.Triage@bethesda.com.au**