The Royal Children's Hospital Melbourne

UR NUMBER
SURNAME
GIVEN NAME(S)
DATE OF BIRTH
AFFIX PATIENT LABEL HERE ↑

Inpatient consultation form

Adolescent Medicine

Referral from (Team & Consultant):

Aim of referral

O Opinion O Transfer patient to adolescent medicine inpatient team

What is the specific question to be addressed in this consultation?

Clinical history / examination / relevant investigations

Brief description of history from psychosocial screening:

(Refer clinical practice guidelines "engaging with and assessing the adolescent patient" if needed)
http://www.rch.org.au/clinicalguide/guideline_index/Engaging_with_and_assessing_the_adolescent_patient/

Home

Education / school / work

Eating / dieting / weight change / exercise

Activities / interests

Drugs / alcohol

Sex / relationships

Self harm / suicide / depression

Date: **Signed:** **Name (print):** **registrar / fellow / consultant***

Contact details (pager / mobile)*

**The team being consulted is encouraged to call the referring doctor just before seeing the patient. If the referring doctor can attend during the consultation this can facilitate optimum communication and can be very educational.*

Inpatient consultation form MR890/A

Consulting team opinion / report

UR NUMBER
SURNAME
GIVEN NAME(S)

Team / Consultant:			
Date:	**Signed:**	**Name (print):**	**registrar / fellow / consultant***
Date:	**Signed:**	**Name (print):**	**registrar / fellow / consultant***
Contact details (pager / mobile)			

**In some services it is usual for the registrar / fellow to provide the initial report. There is space here for the consultant to co-sign the report and add additional comments.*