The Royal Children's Hospital Melbourne

REFERRAL FORM

ACADEMIC CHILD PSYCHIATRY UNIT

Royal Children's Hospital, 50 Flemington Road, Parkville VIC 3052
Tel: (03) 9345 4666 Fax: (03) 9345 6002 Email: karen.dally@rch.org.au

Date of referral: ______________________ **Referrers details (name, address, ph/fax/email/PN):**
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____
____

RCH Mental Health patient: Y / N **Other Professionals Involved with Case:**
____
____

Name of patient: ____ **U.R:**________________

D.O.B.: ___________________ **Age:** _______ **Address:** __________________________________
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Name of parent(s)/carer(s) ____

Phone No: _____________________**Mobile:**____________________ **Email:** ________________

School: ____ **Grade/Year**: _______

FAMILY CONSTELLATION:

PRESENTING PROBLEMS:

BRIEF DIAGNOSTIC FORMULATION:

CONTACT WITH CASE TO DATE (Please tick)

- ☐ Assessment only
- ☐ Individual Psychotherapy/ counselling
- ☐ Group therapy
- ☐ Structured CBT program
- ☐ Parent counselling
- ☐ Parent group
- ☐ Family therapy
- ☐ Medication (please specify)
- ☐ Consultation & Liaison with other services (incl. school)
- ☐ Special education
- ☐ Motor program
- ☐ Speech & Language program
- ☐ Monitoring of progress
- ☐ Other (please specify)

QUESTIONS YOU WOULD LIKE ANSWERED FROM THIS REFERRAL:

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Please email, fax, or mail completed referral forms as per the details shown above