



**The Sutherland Hospital and Community Health Service**  
(A facility of South East Health)

Kingsway, Caringbah  
Locked Bag 21, Taren Point 2229  
Ph: **9540 7474** Fax: **9540 7472**

**ACCESS Team**  
**Division of Mental Health**  
**GP REFERRAL FORM**

To make a referral, please fax this form. We will contact the client. You are welcome to call us to discuss the referral.

**CLIENT DETAILS:**

NAME: .....  
DOB: .....  
ADDRESS: .....  
.....  
PHONE NO: .....

**REFERRER DETAILS:**

NAME: .....  
DOB: .....  
ADDRESS: .....  
.....  
PHONE NO: .....

Interpreter required: Yes  No  Are you the client's usual GP?: Yes  No

We will provide an initial phone triage to determine clinical needs. If mental health needs are identified, a comprehensive assessment will be provided and referrals made to the most appropriate services. **If the client, in your opinion, requires urgent assessment, then please make a VERBAL referral in addition to the fax.**

**CURRENT RISKS:**

If the client is at risk of harm to self or others:

- 1) What are their current suicidal / homicidal thoughts?  
.....  
.....
- 2) Do they have a plan and what is it?  
.....  
.....
- 3) Do they intend to carry out their plan?  
.....
- 4) What is their history of similar behaviours?  
.....  
.....

**POSSIBLE CLINICAL PROBLEM** (tick one or more boxes):

- Psychosis / Mania                       Depression                       Anxiety Disorder
- Cognitive disorder                       Personality Disorder

Other, please specify: .....

**CO-MORBID PROBLEM** (tick one or more boxes):

- Substance abuse
- Financial / Accommodation
- Lack of / Loss of social support

**MENTAL HEALTH TREATMENT HISTORY:**

Have you provided any treatment for this problem?     Yes    No            *Please provide details:*

Psychological:  
 .....  
 .....  
 .....

Medication:  
 .....  
 .....

Has the client previously received treatment from a mental health professional?    Yes    No  
*Please provide details:*  
 .....  
 .....

Do you have any letters / discharge summaries relating to mental health treatment received by client?  
 Yes    No    *If yes, please attach to fax or send hard copy.*

**RELEVANT MEDICAL HISTORY:**

.....  
 .....

**RELEVANT FAMILY / SOCIAL SUPPORT INFORMATION:**

.....  
 .....

Does the client have care of any dependents?             Yes             No

**OTHER INFORMATION:**

.....  
 .....

Is the client aware of the referral?             Yes             No

- What is the client's attitude to the referral?
- Agreeable and likely to be fully cooperative with the assessment
  - Ambivalent but likely to accept assessment
  - Hostile and refuses to participate in assessment

- What feedback information would you prefer? (tick one or more boxes):
- Phone call as soon as practicable after assessment
  - Letter, posted or faxed after the assessment.

*Thank you for your referral.*