ROYAL PRINCE ALFRED HOSPITAL

RPA WOMEN AND BABIES
PSYCHOSOCIAL REFERRAL FORM

Estimated Due Date:
GP details: Name _______________________________ Address _______________________________
______________________________________________________________________________________
Phone _______________________________ _______________________________

Referral discussed with client? YES □ NO □
Verbal consent for referral given by client? YES □ NO □ (if declined, why?) ________________
Verbal consent to discuss with GP? YES □ NO □

Reason for Referral: (tick one or more)
  Poor support network □ □  Depression □ □  Young parent □ □
  Financial issues □ □  Anxious Mood □ □  Drug health issues □ □
  Housing issues □ □  Postnatal Depression □ □  DOCS involvement □ □
  Relationship Difficulties □ □  Mental health issues (other) □ □  Breastfeeding issues □ □
  Domestic Violence □ □  Childhood Abuse/Neglect □ □  Sexual health issues □ □

Brief explanation for the referral and any other relevant information
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

EDS score: _______________________________

Referred to: _______________________________ Date _______________________________
Referral to: _______________________________ Date _______________________________
  Social Worker □ □  Antenatal Support Midwife □ □
  Perinatal Mental Health/mental health liaison □ □  Perinatal and family drug health □ □
  Early childhood health service □ □  Lactation □ □

Referrer:
Name _______________________________ Designation _______________________________
Signature _______________________________ Date of referral _______________________________

Referral taken by _______________________________ Signature _______________________________ Date ____________
(name of clinician) _______________________________ Print name _______________________________

Outcome:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Please Fax: 9515 7452
To ensure that the referral has been received, a message can be left with Perinatal Mental Health ph 9515 5873
or GP Liaison Midwife ph 0425230662