

**PRINCESS ALEXANDRA HOSPITAL
HEALTH SERVICE DISTRICT
DIVISION OF MENTAL HEALTH**

**REFERRAL TO
TRANSCULTURAL
CLINICAL
CONSULTATION SERVICE**

UR: _____

SURNAME: _____

GIVEN NAMES: _____

DATE OF BIRTH: ____/____/____

MALE

FEMALE

(Affix patient label here)

Date: ____/____/____

Address:

Phone:

Country of Birth: Ethnicity:

Year of arrival in Australia: Interpreter required: Yes No

Preferred Language/LOTE:

Name of referrer: Phone No.:

Organisation:

Address:

Name of GP: Phone No.:

Address:

Health concerns:

.....

.....

Mental health concerns:

Diagnosis (If applicable):

.....

Medication (If applicable):

.....

TREATMENT CATEGORY:

Voluntary

Involuntary

MHA Assessment Documents ITO Forensic Classified Court Order

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MALE

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(Affix patient label here)

Intervention required (please list your requests in point form):

.....
.....
.....
.....
.....
.....
.....

**Fax to: Transcultural Clinical Consultation Service (TCCS)
(07) 3167 8322**

Referral: Accepted Not Accepted by
(Signature)

Print Name: Date: ____/____/____

If referral is not accepted, TCCS has discussed the reason with referral source:

Yes No

Reason for Not Accepting/Plan:
.....
.....

REFERRAL TO TRANSCULTURAL CLINICAL CONSULTATION SERVICE

A consumer's consent form is attached and needs to be completed by the consumer. If the consumer has given verbal consent, please document this on the attached form.