Deafness and Mental Health Statewide Consultation and Liaison Service

DR FRANCES DARK PRIVATE PRACTICE

Named Referral Request – Medical Practitioner Use Only

The below patient is booked to have an appointment and/or treatment at the Woolloongabba Community Health Centre. Please complete this form (or Doctors own referral letter) and fax to 07 3317 1296

Referral to: Dr Frances Dark, Private Practice ____ Fax: (07) 3317 1296

Metro South Addiction & Mental Health Service gives patients the choice of being funded as a bulk-billed or public patient as specified under the National Healthcare Agreement 2012. Bulk billing can occur where the specialist department has received a valid, named referral from a medical practitioner to an approved staff specialist. Patients who elect to be bulk-billed are not charged any fees for their consultation.

Patient Details: **Name:** **Date of Birth:** **Address:** **Medicare:**	**URN:**	***Doctor Stamp:*** **Name:** **Provider No:** **Phone No:** **Fax No:**	
This referral is valid for: ☐ 3 Months (Specialist) ☐ Indefinite ☐ 12 Months ☐ Other_____________		***Reason for Referral:*** ☐ Treatment/management of Mental Illness ☐ Cognitive assessments ☐ Diagnostics ☐ Assessment and reports for NDIS/NDIA ☐ Deafness and Mental health ☐ Other ___________	
Referral to: **Referral to Dr Dark Private Practice Fax: (07) 3317 1296**			
Additional information: *****PLEASE attach MEDICATION LIST, ALLERGIES and CURRENT COMORBIDITIES************ For information, resources, and general or clinical consultation with the **Deafness and Mental Health Team** please phone 0419 023 883 or 07 33171080 **Signature:**_________________________________ **Date:**_________________________________			

TELEPHONE: 07 3317 1080
FAX: 07-3317 1296
ADDRESS: Woolloongabba Community Mental Health Centre, Dr Frances Dark Private Outpatients, Level 2, 228 Logan Road, Woolloongabba QLD 4102

Disclaimer: This document is a referral only and not to be used for Medicolegal purposes

Consumer Registration Form

Name	Date of birth	Date form completed
Gender ☐ M ☐ F	Preferred Title Mr Mrs Ms Dr Other	Medicare number
Current address		Telephone

Fax	Mobile	Email

Preferred form of contact

☐ Phone ☐ Fax ☐ SMS ☐ Email ☐ Writing ☐ Other (please specify)

Relationship status

☐ Never Married ☐ Married/De facto ☐ Separated ☐ Divorced ☐ Widowed

Indigenous status

☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander ☐ Neither

Country of birth	Year of arrival in Australia	Preferred language

Is an interpreter required? ☐ Yes ☐ No	If yes, please indicate below what type of interpreter is required: ☐ AUSLAN ☐ Other:
Employment status	☐ Employed ☐ Home duties ☐ Student ☐ Unemployed

Occupation		Religion	

Pension/benefit

☐ None ☐ Aged ☐ Disability ☐ Repatriation ☐ Sickness ☐ Unemployment

Living situation

☐ Self ☐ With family members ☐ With non-family members ☐ Other

Accommodation

☐ Private residence ☐ Boarding house / hostel ☐ Residential aged care ☐ Shelter / refuge

☐ Other supported accommodation ☐ Homeless ☐ Other

Education level

☐ Primary ☐ Junior secondary ☐ Senior secondary ☐ Degree/Diploma ☐ Trade/Apprentice

☐ Did not attend primary/Secondary ☐ Other (please specify)

Next of Kin / Significant other	Name: Relationship: Phone: Address:

Are you connected with any other service?

☐ NDIS

☐ Aged Care

☐ Employment support

☐ Other Mental Health Service

Please specify: ___________________________________

GP	Name: Phone: Address: Fax:
Preferred method of communication: ☐ Speech ☐ Lip reading ☐ Written ☐ Signing ☐ Finger spelling ☐ Gesture	
Does the consumer use any assistive communication devices? ☐ Yes ☐ No If yes, please state which (e.g. hearing aid, cochlear implant, etc)	

Nature of hearing loss (if known)		
	ONSET	☐ **Pre lingual** (before language acquisition) **Post lingual** (after language acquisition) ☐ In childhood ☐ In early adulthood ☐ In late adulthood
	TYPE	☐ Sensori-Neural ☐ Conductive ☐ Central ☐ Mixed
	LEVEL	☐ Mild ☐ Moderate ☐ Severe ☐ Profound

English language skills (includes spoken, written and reading ability)	☐ Uses/prefers simple, concrete language ☐ Understands simple concrete language ☐ Uses/prefers complex language ☐ Understands complex language
Communication assisted by	☐ Slower speech ☐ Louder speech ☐ Speech (lip) reading ☐ Gestures ☐ Writing ☐ Diagrams ☐ Repetition ☐ Other (please specify):

Additional information

Name and contact details of person making referral

PA754

Queensland Government

Consent to Obtain and Release Information

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F

Metro South Addiction & Mental Health Services Deafness and Mental Health

Consent to Obtain and Release Information

Choose either section 1 or 2 then fill in all information in the Declaration section

1. Consent to Release Information

I, (print full name)………………………………………………………hereby consent to the release of information to (specify if family, carer, significant other, NGO, GP, other Government Agency) ……………………………………………….. relating to my health from the Metro South Addiction & Mental Health Services Deafness and Mental Health

2. Consent to Request Release of Information

I, (print full name) ………………………………………………………. hereby consent (health professional's name) ……………………………………………. of the Metro South Addiction & Mental Health Services Deafness and Mental Health to request information from (specify if family, carer, significant other, NGO, GP, other Government Agency ………………………………………………relating to my health.

Declaration

I understand that this information is to be released to …………………………………………………and will be used to my benefit in providing me the relevant health care.

I understand that I can withdraw from this consent to release information prior to it being processed and forwarded.

Signature: …………………………………………………………….. Date: ………/……../……….

I, (print full name) ………………………………………………………………hereby withdraw my consent to release any information

Signature: …………………………………………………………… Date: ………/………/……….

DO NOT WRITE IN THIS BINDING MARGIN

Consent to Obtain and Release Information