AMC Mental Health Services, Forensic Services
Mental Health, Justice Health & Alcohol and Drug Services

Request to Transfer to Hospital

Name: _____ D.O.B: _____

Gender: ☐ Male ☐ Female ☐ Transgender

Fluent in English: ☐ Yes ☐ No Aboriginal/Torres Strait Islander: ☐ Yes ☐ No

If No, Language Spoken: _____

☐ Mental Health Assessment Unit (Emergency Department) ☐ Adult Mental Health Unit

Other: _____

Reason for Referral: _____

_____

Primary Medical Diagnosis: _____

Primary Mental Health Diagnosis: _____

Other Clinical Information: _____

Daily Living Skills: Is the consumer currently functioning independently? ☐ Yes ☐ No

Independently mobile? ☐ Yes ☐ No

Assistance Required: _____

Current Substance Use: ☐ Yes ☐ No Preferred Substance(s): _____

Pattern of Use: _____

Opiate Replacement Treatment (e.g.; Methadone, Suboxone): ☐ Yes ☐ No

Current Dose: _____ Date of Last Dose: _____

Safety Risks: ☐ Yes ☐ No ☐ Unknown **(refer to attached Brief Risk Assessment for details)**

Mental Health Issues (Please describe symptoms or behaviours): _____

_____

_____

_____

_____

Current Medications (include drug, dose, rate, frequency as appropriate): _____

_____

_____

_____

_____

Referral completed by: (Print name) _____ Signed: _____ Date: _____

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