

Confidential Referral

Parent Infant Program

Parent Infant Program

Parent Infant Program

Acute Psychiatric Unit

Austin Hospital

Studley Road, Heidelberg Vic 3084

Contact details:

Telephone: (03) 9496 6406

Email: **pipreferrals@austin.org.au**

**EMAIL COMMUNICATION via** **pipreferrals@austin.org.au** **is preferred,**

**rather than phone contact, to ensure you receive prompt attention.**

|  |  |
| --- | --- |
| **PATIENT DETAILS** | **PARTNER DETAILS** |
| SURNAME |       | PARTNER SURNAME |       |
| NAME |       | PARTNER NAME |       |
| UR NO. |       |  |
| DATE OF BIRTH |       |
| ADDRESS |       | PARTNER ADDRESS |       |
| HOME PHONE |       | PARTNER HOME PHONE |       |
| MOBILE |       | PARTNER MOBILE |       |
| MHA STATUS | [ ]  INVOLUNTARY [ ]  VOLUNTARY |  |
| PATIENT AWARE OF REFERRAL? [ ]  YES [ ]  NO |
| PATIENT CONSENTING TO ADMISSION? [ ]  YES [ ]  NO |
| **INFANT DETAILS** |
| NAME |       | ANTENATAL |       |
| DATE OF BIRTH |       | ESTIMATED DELIVERY DATE |       |
| HOSPITAL |       | HOSPITAL |       |
| **REFERRER DETAILS** |
| SURNAME |       | NAME |       |
| SERVICE |       |
| PHONE |       | FAX |       |
| EMAIL |       | PREFERRED TIMES TO BE CALLED |       |
| **REASON FOR REFERRAL & GOALS FOR ADMISSION** |
|       |
| **PAST HISTORY** |
|       |
| **RISK ASSESSMENT** |
| **SUICIDAL** | [ ]  THOUGHTS [ ]  PLAN [ ]  INTENT |
| DETAILS:       |
| PAST ATTEMPTS:       |
| **SELF HARM** | [ ]  CURRENT [ ]  PAST |
| DETAILS:       |
| **HARM TO INFANT** | [ ]  CURRENT [ ]  PAST |
| DETAILS:       |
| **MEDICATION** |
|       |
| **CURRENT MEDICAL ISSUES** |
|       |
| **SUPPORTS** |
| **PRIVATE PSYCHIATRIST name** |       | PHONE:       | FAX:       |
| **GENERAL PRACTITIONER name** |       | PHONE:       | FAX:       |
| **MATERNAL CHILD NURSE name** |       | PHONE:       | FAX:       |
| **CASE MANAGER name****Enhanced MCHN**  |      [ ]  YES [ ]  NO  | PHONE:       | FAX       |
| **DHS INVOLVEMENT** |
| NOTIFICATION | [ ]  YES [ ]  NO  | COURT ORDERS | [ ]  YES [ ]  NO  |
| CASE WORKER’S NAME |       | PHONE:       | FAX:       |
| **REFERRER’S SIGNATURE:** |       | DATE:       |

**Please provide/attach any other relevant background information: eg discharge summaries/case reports. A thorough and detailed referral will assist with a timely triage process.**