

Confidential Referral

Parent Infant Program

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Acute Psychiatric Unit

Austin Hospital

Studley Road, Heidelberg Vic 3084

Contact details:

Telephone: (03) 9496 6406

Email: [**pipreferrals@austin.org.au**](mailto:pipreferrals@austin.org.au)

**EMAIL COMMUNICATION via** [**pipreferrals@austin.org.au**](mailto: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.**