

To be completed by SVMHS Clinician

St Vincent's Mental Health Service Rehabilitation Referral Form

**Date of Referral:**

**Client Data**

Name: M.R.N  
Address: Ph:

D.O.B. / / Gender: M / F Language used:

Case Manager: Ph:

Psychiatrist: Ph:

**Referrer** (Please include name, phone number and designation)

**Mental Health Information**

Current Diagnosis Age of onset

Current Medications CTO/CCO (please circle)

Consumer's View of Medication

**Relevant Medical History**

Yes  No  Please specify:

**Substance Misuse**

Yes  No  Please specify:

**History of Aggression/Violence**

Yes  No  Please specify:

Possible triggers:

**Family and/or Social Supports**

**Recent Assessments Completed**

HONOS  K 10  ACL  LSP 39   
Other (please specify)

**Rehabilitation Brochure discussed with Consumer?** Yes  No

Referral for: Clinical Rehabilitation   
For Assessment and linking to Disability Support Services

**Consumers Expectations and reasons for attending Rehab**

**Other Issues/concerns impacting on participation of Rehab Activities**