MSH074

Queensland Government

Metro South Addiction and Mental Health Services

Logan-Beaudesert Perinatal Wellbeing Service Referral

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F

Scan and email form to: WellbeingPerinatal@health.qld.gov.au or fax to (07) 3089 2722

Telephone queries ph. (07) 3089 2734

Date of referral:

Client details

Home phone:	Mobile phone:
Email:	Has the client agreed to the referral? ☐ Yes ☐ No

Baby's details (if applicable)

Name:	Date of birth:	Sex:

Referral details

Reason for referral:

Antenatal - EDC:	Postnatal - number of weeks:

Other relevant medical history:

Mental Health history:

Demographic information

Marital status: ☐ Single ☐ Defacto ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Next of Kin (name): Relationship:

Contact No.:

Country of birth:	Indigenous Status: ☐ Aboriginal but not Torres Strait Islander origin ☐ Torres Strait Islander but not Aboriginal origin ☐ Both Torres Strait Islander and Aboriginal origin ☐ Neither Torres Strait Islander nor Aboriginal origin ☐ Not stated or unknown
Religion:	
Interpreter required? ☐ Yes ☐ No If yes specify language:	

GP details

GP name:		GP address:
GP phone:	GP fax:	GP email:

If the GP is not the referrer, are they aware of the referral? ☐ Yes ☐ No

Referrer details

Name:	Service:
Address:	Phone:
	Email:
Signature:	Designation:

DO NOT WRITE IN THIS BINDING MARGIN

V1.0 06/2015
Locally Printed

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