

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 FScan 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 informationMarital status: Single Defacto Married Separated Divorced Widowed

Next of Kin (name):

Relationship:

Contact No.:

Country of birth:

Indigenous Status:

Religion:

-
- 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

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

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