

# BOiMH Patient Summary Form

**Fax: 3272 7595**

<b>Referring Doctor</b>			
<b>Postcode of General Practice</b>		<b>Date of Referral</b>	
<b>Patient given Patient Information Sheet</b> <input type="checkbox"/> Yes		<b>Informed consent obtained</b> <input type="checkbox"/> Yes	

<b>Patient Name</b>			<b>Gender</b>	<input type="checkbox"/> M <input type="checkbox"/> F
<b>Patient Address</b>			<b>Postcode</b>	
	<b>Mobile Phone</b>	<b>Home/Work Phone</b>	<b>DOB</b>	

<p><b>Does the person speak a language other than English at Home?</b></p> <input type="checkbox"/> No <input type="checkbox"/> Italian <input type="checkbox"/> Cantonese <input type="checkbox"/> Arabic <input type="checkbox"/> Greek <input type="checkbox"/> Mandarin <input type="checkbox"/> Vietnamese <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____ <p><b>How well does the person speak English?</b></p> <input type="checkbox"/> Very well <input type="checkbox"/> Well <input type="checkbox"/> Not Well <input type="checkbox"/> Not at all <input type="checkbox"/> Unknown <input type="checkbox"/> Interpreter required Language _____ Ethnic group _____ <p><b>Is the person of Aboriginal or Torres Strait Islander origin?</b></p> <input type="checkbox"/> No <input type="checkbox"/> Yes (Aboriginal) <input type="checkbox"/> Yes (Torres Strait Islander) <input type="checkbox"/> Unknown <p><b>Highest Level of Education Completed?</b></p> <input type="checkbox"/> Primary or below <input type="checkbox"/> Year 8,9 or 10 <input type="checkbox"/> Year 11 <input type="checkbox"/> Year 12 <input type="checkbox"/> Tertiary	<p><b>Does the person live on his/her own?</b></p> <input type="checkbox"/> No <input type="checkbox"/> Yes <p><b>Is the person a low-income earner?</b></p> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <p><b>Has the person ever received specialist mental health care before?</b> (public/private, medical, allied health)</p> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <p><b>Kessler 10 Score:</b> _____</p> <p><b>Edinburgh Score:</b> _____</p> <p><b>DASS Score:</b> _____</p> <p><b>GAF/CGAS Score:</b> _____</p> <p><b>Strengths &amp; Difficulties Questionnaire:</b> _____</p> <p><b>Primary Diagnosis:</b> ( tick all that apply)</p> <input type="checkbox"/> Depression <input type="checkbox"/> Perinatal Depression <input type="checkbox"/> Adjustment disorder <input type="checkbox"/> Panic Disorder <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Psychotic disorder <input type="checkbox"/> Conduct Disorder <input type="checkbox"/> Hyperkinetic Disorder (ADD) <input type="checkbox"/> Unexplained somatic disorders <input type="checkbox"/> Other: _____	<p><b>Other Presenting Issues:</b></p> <input type="checkbox"/> Alcohol and/or drug use <input type="checkbox"/> Self injurious behaviour <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Corrective Services history <input type="checkbox"/> Torture history <input type="checkbox"/> Trauma history <input type="checkbox"/> Sexual disorders <input type="checkbox"/> Sleep disorder <input type="checkbox"/> Bereavement <input type="checkbox"/> Homeless/ at risk of _____ <p><b>Suicide Risk</b></p> High (Not for clients in crisis) <input type="checkbox"/> Moderate (Plan, ambivalent) <input type="checkbox"/> Low (Suicide Ideation) <input type="checkbox"/> Previous attempt <input type="checkbox"/> Other _____ <p><b>Referred for which strategies</b> (please tick all that apply)</p> <input type="checkbox"/> Diagnostic Assessment <input type="checkbox"/> Psycho-Education <input type="checkbox"/> Interpersonal Therapy <input type="checkbox"/> Cognitive Intervention (CBT) <input type="checkbox"/> Behavioural Intervention (CBT) <input type="checkbox"/> Relaxation Strategies (CBT) <input type="checkbox"/> Skills Training (CBT) <input type="checkbox"/> Other intervention: _____ <p><b>Receiving Psychotropic Medication</b> (please tick all that apply)</p> <input type="checkbox"/> None <input type="checkbox"/> Benzodiazepines & Anxiolytics <input type="checkbox"/> Anti-Depressants <input type="checkbox"/> Phenothiazines & Tranquilisers <input type="checkbox"/> Mood Stabilisers <p><b>Client availability (circle)</b></p> Mon      Tues      Wed Thurs      Fri      am/pm
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