EMR503790

Women and Newborn Health Service
King Edward Memorial Hospital

WNHS MENTAL HEALTH SERVICE NEW BEGINNINGS PROGRAM REFERRAL FORM

Med Rec. No: .....
Surname: .....
Forename: .....
Gender: ..... D.O.B. .....

UMRN ONLY

REFERRAL DATE:

REFERRER DETAILS

Name:

Contact address:

Telephone:

Email:

GP DETAILS

Name:

Practice:

Telephone:

Email:

CLIENT DETAILS

Name:

Medical Record Number:

Address:

Date of Birth:

Contact Number:

Email:

☐ Aboriginal or Torres Strait Islander ☐ CALD Languages spoken:

Next of Kin:

Contact Number:

Children's Details

Name	DOB / Age	Gender

Services / Agencies currently involved

DO NOT WRITE IN BINDING MARGIN

HCHKEFMR209H

KE779
09/24

NEW BEGINNINGS PROGRAM REFERRAL FORM

MR209.08

Women and Newborn Health Service
King Edward Memorial Hospital

WNHS MENTAL HEALTH SERVICE NEW BEGINNINGS PROGRAM REFERRAL FORM

Med Rec. No: .....

Surname: .....

Forename: .....

Gender: ..... D.O.B. .....

Reasons for Referral:

EPDS Score:

Anxiety Subscale: Date completed:

Special Considerations

☐ Mental Health ☐ Socially isolated / lacking support ☐ Family / social complexities

☐ Infant physical / medical / developmental concerns

Additional information

Current Alcohol / Drug use YES ☐ NO

☐ Alcohol ☐ Cigarettes / Vaping ☐ Other drugs

Current Medication

Referral has been discussed with the client and they are happy to be contacted

YES ☐ NO

Please email the completed form:

WNHS.MHS.NewBeginnings@health.wa.gov.au

Once the referral has been reviewed you will be contacted and informed of the outcome.

OFFICE USE ONLY:

☐ Email to referrer to confirm referral received Date

☐ SMS to participant to confirm referral received Date

☐ Email to confirm referral received Date