**LUCENA CLINIC CHILD AND ADOLESCENT MENTALHEALTH SERVICE - REFERRAL FORM**

**CLIENT CONTACT INFORMATION**

Child's name: _____ DOB: ___ /__ /___ Sex: M / F

Mother's name: _____ Father's name: _____

Address: _____ Address: _____

_____ _____

Telephone: _____ Telephone: _____

Consent to referral: Y / N (circle) Consent to referral: Y / N (circle)

Who has legal guardianship of this child/young person: _____

**PRESENTING COMPLIANT:**

_____

_____

_____

_____

_____

_____

**MENTAL STATE EXAMINATION:**

_____

_____

_____

_____

_____

**RISK ASSESSMENT:**

**Suicidal ideation (acute or passive):**

**Suicide attempts:**

**Deliberate self-harm:**

**Access to method of self-harm / suicide:**

**Risk to others (aggressive behaviour, threats of harm):**

**PSYCHIATRIC HISTORY (previous assessments and interventions)**

_____

_____

_____

**MEDICAL HISTORY:**

_____

_____

_____

**DEVELOPMENTAL HISTORY:**

_____

_____

_____

**MEDICATION**:_____**ALLERGIES:**_____

**G.P.'S CONTACT INFORMATION**

Name: _____

Address: _____ Phone No: _____

_____ Fax No: _____

_____ Email Address: _____

**Signature of GP: _____Date:** ___ /___ / ___