



EMR503790

DO NOT WRITE IN BINDING MARGIN

HCHKEFMR209H

KE779
09/24Women 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.

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

NEW BEGINNINGS PROGRAM REFERRAL FORM
MR209.08

**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 |