NSW Health
Sydney Local Health Network

ROYAL PRINCE ALFRED HOSPITAL

RPA WOMEN AND BABIES
PSYCHOSOCIAL REFERRAL FORM

SURNAME	MRN
OTHER NAMES	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Estimated Due Date:

GP details: Name _____ Address _____

_____ Phone _____

Referral discussed with client? YES ☐ NO ☐

Verbal consent for referral given by client? YES ☐ NO ☐ (if declined, why?)_____

Verbal consent to discuss with GP? YES ☐ NO ☐

Reason for Referral: (tick one or more)

	Past	Present		Past	Present		Past	Present
Poor support network	☐	☐	Depression	☐	☐	Young parent	☐	☐
Financial issues	☐	☐	Anxious Mood	☐	☐	Drug health issues	☐	☐
Housing issues	☐	☐	Postnatal Depression	☐	☐	DOCS involvement	☐	☐
Relationship Difficulties	☐	☐	Mental heath issues (other)	☐	☐	Breastfeeding issues	☐	☐
Domestic Violence	☐	☐	Childhood Abuse/Neglect	☐	☐	Sexual health issues	☐	☐

Brief explanation for the referral and any other relevant information

_____

_____

_____

_____

_____

EDS score:

Referred to:		Date	Referred to:		Date
Social Worker	☐	_____	Antenatal Support Midwife	☐	_____
Perinatal Mental Health/mental health liaison	☐	_____	Perinatal and family drug health	☐	_____
Early childhood health service	☐	_____	Lactation	☐	_____

Referrer:

Name _____ Designation _____

Signature _____ Date of referral _____

Referral taken by _____ Signature _____ Date _____
(name of clinician) Print name

Outcome: _____

_____

_____

_____

_____

_____

_____

_____

Please Fax : 9515 7452

To ensure that the referral has been received, a message can be left with Perinatal Mental Health ph 9515 5873 or GP Liaison Midwife ph 0425230662

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MRA4