



The Royal  
Melbourne Hospital  
NorthWestern  
Mental Health

**Neuropsychiatry Referral Form**  
Neuropsychiatry, Level 2, John Cade Building  
Royal Melbourne Hospital 3050  
T: 03 9342 8750  
F: 03 9342 8483  
E: [NPSReferrals@mh.org.au](mailto:NPSReferrals@mh.org.au)

ATTACH LABEL OR RECORD PATIENT DETAILS

LOCAL UR

MH UR

NAME

ADDRESS

TELEPHONE

DOB

SEX

### REFERRER DETAILS

Name:

Role:

Organisation name:

- |  |   |
|--|---|
| <input type="checkbox"/> Area Mental Health Service (public) | <input type="checkbox"/> Private Neurologist  |
| <input type="checkbox"/> Private Psychiatrist                | <input type="checkbox"/> Melbourne Health/RMH |
| <input type="checkbox"/> General Practitioner                | <input type="checkbox"/> Other Hospital       |
| <input type="checkbox"/> Other Service/Agency                |   |

Address:

Email:

Mobile number OR Direct number required:

Fax:

### PATIENT DETAILS

Surname:

First name:

Gender:

Date of birth:

Address:

Telephone:

Contact person (incl phone number):

Interpreter required? (specify language):

### REFERRAL CHECKLIST (ALL REQUIRED)

- Referral Letter (referral question clearly stated please)
- Other reports/summaries/relevant correspondence
- Investigation results – biochemical, imaging
- Neuroimaging reports incl name of radiology service, location, date
- Patient/carer accepting of referral

### REFERRAL REASON

- Diagnostic
- Young-onset dementia
- Huntington's Disease
- DBS Assessment
- Cognitive Assessment & Advisory Service (CAAS) (NWMH Neuropsychology)
- Other (specify)

Patient suitability to participate in:

- |                                    |                                     |                                     |
|------------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Inpatient | <input type="checkbox"/> Outpatient | <input type="checkbox"/> Telehealth |
|------------------------------------|-------------------------------------|-------------------------------------|



NWMH312



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**INTERNAL USE FOR NEUROPSYCHIATRY ONLY**

Referrer Contacted (Date \_\_\_\_\_)

**Clinician Responsible**

**OUTCOME**

Inpatient Waiting List IPWL

**Outpatient neuropsychiatry**

General Clinic

HD Clinic

Predictive HD

DBS Assessment

Epilepsy

ECT

YOD Clinic

In-person/clinic

Telehealth

Off Site Assessment (OSA)

Consultation Liaison Assessment (CL)

Referral Not Accepted/Other Service More Appropriate

Referral Withdrawn

By Patient/Relative

By Referrer

Phone Advice

**FURTHER ACTION/COMMENTS**

**Date**

**Action**

**Who**