

# CLIPP Program Referral Form



If you think that someone might be suitable for GP shared care, please consider the items below and complete this form.

## CLIENT INFORMATION

DATE: / /

Name:		
Address:		Phone No:
Sex: M / F	D.O.B: / /	U.R No:
Preferred Language:		Interpreter Needed?: Yes <input type="checkbox"/> No <input type="checkbox"/>

## REFERRERS INFORMATION

Name:
Team:
Phone:

### Psychiatric Diagnoses & other disabilities:

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### Psychiatric History:

Hospitalisations: Please Tick how many: 0  1  2-5  >5   
 Time since Last One: 0-6 months\*  6-12 months  >12 Months

CATS episodes: Please Tick how many: 0 1 2-5 >5  
 Time since Last One: 0-6 months\*  6-12 months  >12 Months

History of Self Harm? Yes  No  If Yes, Recent? Yes\*  No   
 History of Harm to Others: Yes  No  If Yes, Recent? Yes\*  No   
 Drug/Alcohol Problems Yes  No  If Yes, Current? Yes\*  No

### Current Medication

Drug	Dose	Frequency	Drug	Dose	Frequency

### Approximate usual Frequency of appointments with Area Mental Health Staff

Include all clinical contacts:  
 <1 per month  1 per month to 1 per fortnight  >1 per week\*

### Likely responsiveness of Client/Carers to Transfer

Very positive  Positive Indifferent  Negative  Very Negative  Don't Know

Does the client have established contact with a particular GP Yes  No

Name Address of GP: \_\_\_\_\_

### Living Situation:

Alone Yes\*  No  Is there an identified Carer? Yes  No\*

Dependent Children? Yes  No

Now please pass the form to the CLIPP liaison case manager, who will contact you to discuss the client and the possibility of their transfer into GP shared care.

Signature \_\_\_\_\_

\* Probably unsuitable, but there may be exceptions, and if you think this may be one, discuss directly with CLIPP liaison case manager.