



PR1A

REGISTRATION (PR1A) Legal and Clinical

Your must also complete PR1 as part of registration

Local Patient Identifier

FAMILY NAME

Alerts

GIVEN NAMES

ALIAS

Mental Health Statewide UR Number

DATE OF BIRTH

SEX

GENDER

Place patient identification label above

Diagnosis

MHA Legal Status	<input type="checkbox"/> CAO	<input type="checkbox"/> ITO	Sentencing Act Status	<input type="checkbox"/> Court CAO	CMIA	<input type="checkbox"/> CSO	<input type="checkbox"/> NCSO Apprehend	
	<input type="checkbox"/> IAO	<input type="checkbox"/> CTO		<input type="checkbox"/> Court IAO		<input type="checkbox"/> CSO leave		<input type="checkbox"/> Remand
	<input type="checkbox"/> ITTO	<input type="checkbox"/> STO		<input type="checkbox"/> Court STO		<input type="checkbox"/> CSO susp leave		<input type="checkbox"/> Other
	<input type="checkbox"/> CTTO	<input type="checkbox"/> None				<input type="checkbox"/> NCSO		

Other legislation

<input type="checkbox"/> Severe Substance Dependence (SSDTA)	<input type="checkbox"/> Other Court Order	<input type="checkbox"/> Guardian order (GAAA)
<input type="checkbox"/> Disability Act	<input type="checkbox"/> Child Youth & Families Act	<input type="checkbox"/> Administrator order (GAAA)

Advance Statement	Does this person have an advance statement of preferences? <input type="checkbox"/> Yes <input type="checkbox"/> No	Compulsory Notification	Date made				
			<input type="checkbox"/> Yes <input type="checkbox"/> No	Date entered into CMI.			
Details:		Statement of Rights explained		<input type="checkbox"/> Yes	<input type="checkbox"/> No		

ASSESSMENT AND CASE MANAGEMENT SECTION: This is optional if you record these details in a clinical information system or on separate clinical forms.

Date commenced						Time				Date Closed					
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Assessment Type

<input type="checkbox"/> Intake – centre based	<input type="checkbox"/> Admission	<input type="checkbox"/> Other
<input type="checkbox"/> Review	<input type="checkbox"/> Intake – Crisis Community Based	

Assessment Outcome

<input type="checkbox"/> Commence case	<input type="checkbox"/> Client declined further service	<input type="checkbox"/> Referral to other health care agency
<input type="checkbox"/> No further action	<input type="checkbox"/> Referral to GP	<input type="checkbox"/> Assessment- cancelled
<input type="checkbox"/> Referral to Private Psychiatrist	<input type="checkbox"/> Assessment – not completed	<input type="checkbox"/> Referral to other mental health provider

Referral Details

Client referred to:

Address: _____ Telephone: _____

English Proficiency

<input type="checkbox"/> Speaks English very well	<input type="checkbox"/> Does not speak English well	<input type="checkbox"/> Not stated/ Unknown
<input type="checkbox"/> Speaks English well	<input type="checkbox"/> Does not speak English at all	

Case Management Details – Name	Discipline	Date appointed

Diagnosis	ICD 10 AM	Diagnosis	ICD 10 AM

Comments and Notes

NOTE: Registration is not complete until PR 1 and PR 1A are completed, dated and signed

Signature: _____ Date: _____
signature of practitioner

Given Names: _____ Family Name: _____

Designation: _____ Telephone: _____

ROLLS AUSTRALIA 1300 600 192

JULY 2023

Original – medical record

Copy – office use

REGISTRATION- Legal and Clinical

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