Specialist Mental Health Intellectual Disability Service – SMHIDS

Assessment Referral Form

Client Name:	Client DOB:
Client Address:	Diagnosis:
Person requesting assessment: Relationship to client: Contact number:	Guardian: Contact number:
Support Agency: Contact number:	Name of GP: Contact number:

REASONS FOR REFERRAL: (Only tick the boxes that identify the reason/s for referral and provide details on the assessment being requested please)

☐ Mental Health Assessment	☐ Opinion on Risk to Self and/or Others
☐ Medication Review	☐ Opinion on Containment/Restraint
☐ Review of Physical/Medical Issues	☐ Opinion on Psycho-Social/Family Issues
☐ Opinion on Causes for Challenging Behaviour	☐ Capacity Assessment
☐ Opinion on Contributing Environmental Factors	
☐ **Other** – Please specify below (e.g. FASD training/assessment, ABI)	

Details of assessment requested:

_____

Name

Date: / /

SMHIDS Office Use Only

Date Referral Received:	Allocated to:
Date Assessment Completed:	Date Report Completed:
Assessment comments:	

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