the day clinic
treatment in life

REFERRAL FORM

Referred by:..... Email:.....
Tel:..... Date:.....
Psychiatrist ☐ GP ☐ Psychologist ☐ Social Worker ☐ Teacher ☐ Parent ☐ Self ☐
Other (please specify) ☐ .....
Other medical professionals ☐ .....

Patient name:.....
Age: ..... Date of birth.....
Email:..... Tel (patient):.....
Tel and name (family member):.....
Relationship to patient:.....
School:..... Grade: ..... Teacher: .....

Which of the following does the patient have difficulty with?

Mood swings	☐	Insomnia	☐	Panic attacks/anxiety	☐
Depression	☐	Lethargy/fatigue	☐	Loss of interest/numbing	☐
Irritability/anger	☐	Chronic pain	☐	Poor concentration & memory	☐
Hopelessness	☐	Nightmares	☐	School deterioration	☐
Suicidality	☐	Substance misuse	☐	Deliberate self harm	☐
Eating disorders	☐	Impulsivity	☐	Behavioural difficulties	☐
Ruminating thoughts	☐	Identity confusion	☐	Interpersonal difficulties	☐

Other symptoms: _____

_____

_____

_____

Past & current treatment including medication, psychotherapy, speech therapy, occupational therpy, remedial therapy:

_____

_____

_____

_____

Relevant developmental/medical history:

Recent traumas, separations, divorce, bereavements or significant life events:

Family psychiatric history:

Current medication:

DSM 5 Diagnosis (Professionals only):

Please feel free to send any additional information that you deem necessary. This information will be treated confidentially by The Day Clinic team.

Email: *referrals@thedayclinic.co.za* Tel: 010 350 0350