



REFERRAL FORM

Referred by:..... Email:.....
Tel:..... Date:.....

Psychiatrist Other Medical Specialist (Please specify) GP Psychologist
Social Worker Nurse Teacher Self Other (Please specify)

Patient name:..... Age: Date of birth.....
Email:..... Tel:.....(patient) Tel:.....(family member)
Medical Aid: Medical Aid No:

Which of the following does the patient have difficulty with?

- | | | | | | |
|--------------------|--------------------------|---------------------|--------------------------|-----------------------------|--------------------------|
| Mood swings | <input type="checkbox"/> | Insomnia | <input type="checkbox"/> | Panic attacks/anxiety | <input type="checkbox"/> |
| Depression | <input type="checkbox"/> | Lethargy/fatigue | <input type="checkbox"/> | Loss of interest/numbing | <input type="checkbox"/> |
| Irritability/anger | <input type="checkbox"/> | Chronic pain | <input type="checkbox"/> | Poor concentration & memory | <input type="checkbox"/> |
| Hopelessness | <input type="checkbox"/> | Nightmares | <input type="checkbox"/> | Medication overuse | <input type="checkbox"/> |
| Suicidality | <input type="checkbox"/> | Substance misuse | <input type="checkbox"/> | Deliberate self harm | <input type="checkbox"/> |
| Eating disorders | <input type="checkbox"/> | Impulsivity | <input type="checkbox"/> | Behavioural difficulties | <input type="checkbox"/> |
| Dissociation | <input type="checkbox"/> | Identity confusion | <input type="checkbox"/> | Interpersonal difficulties | <input type="checkbox"/> |
| Flashbacks | <input type="checkbox"/> | Ruminating thoughts | <input type="checkbox"/> | School/work deterioration | <input type="checkbox"/> |

Past & current psychiatric treatment including psychotherapy:

Relevant medical history:

Current medication:

DSM 5 Diagnosis: (Professional referrals only)

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

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

Thank you for your referral