

REFERRAL FORM: DV BRYANT TRUST RAGLAN RETREAT FOR WOMEN
PO Box 19318, Hamilton 3244
Phone: (07) 8380522 - Fax (07) 8342264

Guest Name

Including previous Names

Address

Telephone Number

Mobile No.

Email address:

Age

Marital Status

Ethnicity

Age of dependents if any

Has guest ever been to the Retreat

If so, when

GP Name

Practice Name:

Address

Phone Number

Fax No.

Email:

website:

Date of Referral

Current Diagnosis/Long Term Classifications

Reason for Referral

Relevant medical and surgical history e.g. epilepsy, diabetes

Current Medications

If mental illness present comment on severity and / or patient's stability

Comment on patient's ability to relate to others

Summary of current supports / treatments

Contact details of other agencies / professionals involved

Patient Goals for stay at the Retreat

Checklist

Guest aged between 25 and 65	
No safety issues (e.g. suicide risk, domestic violence)	
Ambulatory and not requiring nursing care	
Guest has clear goals for stay	
Guest is willing for this information to be provided to Bryant Trust	
Guest is able to administer her own medication	
Patient consents to Trust contacting other professionals as listed above	
If mental condition is present, the severity is currently mild, stable and controlled	
Level of functioning suitable for a group stay	
Patient has sighted this referral form and signed below	

GP Signature _____

Patient Signature _____