



PANDA

Perinatal Anxiety & Depression Australia

PANDA - Perinatal Anxiety & Depression Helpline Referral Form

Once all sections of the form have been completed please return to our office via fax
(03) 9482 6210

All referrals will be triaged, please provide as much information as possible

Referrer Details

Referrer Organisation		Street Address	
<input type="text"/>		<input type="text"/>	
Suburb	State	Postcode	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
First Name	Last Name		
<input type="text"/>	<input type="text"/>		
Position	Job Title		
<input type="text"/>	<input type="text"/>		
Phone	Fax Number		
<input type="text"/>	<input type="text"/>		
Email			
<input type="text"/>			

Client Details

First Name	Last Name	Date of Birth
<input type="text"/>	<input type="text"/>	<input type="text"/>
Gender		
<input type="checkbox"/> Male		
<input type="checkbox"/> Female		
<input type="checkbox"/> Other		
Street Address		Suburb
<input type="text"/>		<input type="text"/>
State	Postcode	
<input type="text"/>	<input type="text"/>	

Phone Number

Email (Where possible, please provide)

Consent for PANDA to leave a message?

Yes

No

Aboriginal or Torres Strait Islander?

Yes

No

Language spoken at home

Interpreter Needed?

Yes

No

Born in Australia

Yes

No (if no please specify)

Where were they born?

Yes

No

Has the client ever received specialist mental health care?

Yes

No

Perinatal Status

Antenatal

Estimated Delivery Date:

Postnatal

Weeks Postpartum:

D.O.B

Infant's First Name

Infant's Surname

Names and DOB of other children (If any)

GP Name and Practice

Other health professionals/services currently involved:

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Diagnosis (if any):

- Perinatal Depression
- Perinatal Anxiety
- Bipolar Disorder
- Obsessive Compulsive Disorder
- Borderline Personality Disorder
- Eating Disorder
- Other

Screening Tool Used

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Screening Score

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Date

--

Current Medications

--

Past Medications

--

Current Symptoms

--

Current Supports

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Mental Health History

Reason For Referral

Other Referrals Made (e.g acute mental health triage, helplines, counselling, family services, medical)

Risk Assessment

Suicide	Self Harm	Alcohol and Drug Use	Family Violence
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown

Please Specify

Record of Client Consent

The client agrees that the above information may be shared with PANDA in order for them to contact me and offer support.

Tick to confirm verbal consent has been given

I the referrer have discussed the referral with the client and am satisfied that they understand the proposed uses and disclosures and have provided their informed consent to these.

Tick to confirm you have discussed this with client