



A member of Bayside Health

REFERRAL FORM

ALFRED CHILD AND ADOLESCENT
MENTAL HEALTH SERVICE
2nd Floor, 999 Nepean Hwy, Moorabbin
Victoria 3189 Australia
Telephone: (03) 8552 0555
Facsimile: (03) 9532 5631

To which mental health program are you referring? (Please tick one box only)

- Infant** 0 – 3yo
- Developmental** For complex developmental issues such as Autism and Aspergers 2-18yo
- General Clinic** 3 – 18yo

REFERRER DETAILS

Your Name: _____

Address: _____

Phone: _____

Fax: _____

Email: _____

CLIENT DETAILS

Child's Name: _____

Address: _____
 _____ Phone: _____

Age: _____ Grade: _____ D.O.B: ____ / ____ / ____

School: _____

Parent/Carers Name: _____

Child lives with: both parents / mo / fa / other

1. **What is the purpose of this referral?
What are the mental health concerns requiring assessment?**

2. **Are there other concerns in relation to this child, such as learning, academic, social / environmental factors (if not already described)?**

3. **Please confirm that the parent/carers have agreed to this referral and understand the referral reasons specified above: YES / NO**

Return to ACAMHS Intake. - See contact details at top of Referral form