Health
South Eastern Sydney
Local Health District

MENTAL HEALTH REGISTRATION FORM

Title: Mr / Mrs / Ms / Miss / Master / Dr / Prof / Father / Sister / Other _____ (Please circle)

SURNAME: _____ **First Name:** _____

Aliases: (if you have ever been known by another name, eg maiden name): _____

Sex: Male / Female (Please circle) **DOB:** _____ **Age:** _____

Address: _____

Home Telephone: _____ **Mobile:** _____

Country of Birth: _____ **Language:** _____ **Interpreter:** Yes / No

Email: _____

Marital Status: 1. Never Married 2. Widowed 3. Divorced 4. Separated 5. Married (incl. Defacto) (Please circle)

Aboriginal and/or Torres Strait Island Origin | Neither: (Please circle if applicable)

Medicare No: _____ **Exp:** _____/_____ **Ref:** _____

Dept. of Vet Affairs No: _____ **Card Type:** _____

Health Fund: _____ **Policy No:** _____

Person to contact 1: _____ **Relationship:**_____

Title: Mr / Mrs / Ms / Miss / Dr / Prof / Father / Sister / Other _____ (Please circle)

Address: _____

Home Phone: _____ **Mobile:** _____

Country of Birth: _____ **Language:** _____ **Interpreter:** Yes / No

Aboriginal & Torres Strait Island Origin: Yes / No **Sex:** Male / Female **DOB:** _____

General Doctor (GP Not specialist):

Name: _____

Practice Address: _____

_____

Phone: _____ **Fax:** _____

Provider Number: _____

Euroa Centre, Prince of Wales Hospital
Phone 938 23763 Fax 938 23774

Next of Kin / Guardian _____ Relationship _____

Address _____

_____

Telephone(s) _____ Mobile _____

Fax _____ Email _____

.....

Key Worker (if different from above) _____

Address _____

_____

Telephone(s) _____ Mobile _____

Fax _____ Email _____

.....

Specialist _____

Address _____

_____

Telephone(s) _____

Fax _____ Email _____

.....

Other Professionals/Agencies currently involved:

_____

_____

_____

Name of person completing this form and relationship to patient:

_____

Referred by _____

Main reason(s) for referral:

_____

_____

_____

Has a comprehensive health check been done by a doctor in the last 1-2 years?

(e.g. CHAP) ☐ **yes** ☐ **No**

If yes, please give date and name of doctor _____

Level of Intellectual Disability

☐ **None** ☐ **Mild** ☐ **Moderate** ☐ **Severe** ☐ **Profound** ☐ **Not known**

Cause of intellectual disability (if known):

_____

_____

MAIN HEALTH CONDITIONS/PROBLEMS:

1. _____ **5. _____**

2. _____ **6. _____**

3. _____ **7. _____**

4. _____ **8. _____**

CURRENT MEDICATIONS

(include over the counter/herbal/complementary/vitamins)

Medication	Dose/ Frequency/commencement date

PREVIOUS MEDICATIONS

Medication	Cessation date/ Reason

ALLERGIES/ADVERSE DRUG REACTIONS:

_____

_____

VISION CHECK: ☐ Yes Date_____Results_____

☐ No

☐ Don't know

HEARING CHECK: ☐ Yes Date_____Results_____

☐ No

☐ Don't know

DENTAL CHECK: ☐ Yes Date_____Results_____

☐ No

☐ Don't know

EPILEPSY:

Any seizures in the past ☐ Yes ☐ No

Seizure within last 5 years ☐ Yes ☐ No

If yes, Type(s) of seizures (or description of seizure)

_____

At what age did the seizures start? _____

Frequency of seizures _____

Duration of seizures _____

Date of last Seizure _____

Epilepsy Management Plan ☐ Yes (please bring it to the appointment) ☐ No

WOMEN'S HEALTH (if applicable):

Menstrual Periods	☐ Yes	☐ No	☐ Not known
Premenstrual tension	☐ Yes	☐ No	☐ Not known
Midcycle Bleed	☐ Yes	☐ No	☐ Not known
Painful Periods	☐ Yes	☐ No	☐ Not known
Vaginal Discharge	☐ Yes	☐ No	☐ Not known

Date of last normal menstrual period **__/__/__**

Pap smear ☐ Yes (date **__/__/____**) ☐ No ☐ Not known

Mammogram ☐ Yes (date **__/__/____**) ☐ No ☐ Not known

If yes, results _____

BEHAVIOUR:

Are there any behaviour difficulties ☐ Yes ☐ No

If yes, please describe in detail

_____

_____

_____

_____

_____

Mood (Please describe)

_____

_____

PAST MEDICAL HISTORY:

Illnesses: _____

_____

_____

_____

Operations: _____

_____

Accidents/Fractures: _____

_____

Other Hospital Admissions: _____

Immunisation:

Diphtheria/Tetanus (ADT)	☐ Yes (last dose__/__/__)	☐ No	☐ Don't know
Tetanus vaccine	☐ Yes (last dose__/__/__)	☐ No	☐ Don't know
Polio vaccine	☐ Yes (last dose__/__/__)	☐ No	☐ Don't know
Measles	☐ Yes (last dose__/__/__)	☐ No	☐ Don't know
Rubella (German measles)	☐ Yes (last dose__/__/__)	☐ No	☐ Don't know
Meningococcal vaccine	☐ Yes (last dose__/__/__)	☐ No	☐ Don't know
Hepatitis A vaccine	☐ Yes (last dose__/__/__)	☐ No	☐ Don't know
Hepatitis B vaccine	☐ Yes (last dose__/__/__)	☐ No	☐ Don't know
Influenza vaccine	☐ Yes (last dose__/__/__)	☐ No	☐ Don't know
Pneumococcal vaccine	☐ Yes (last dose__/__/__)	☐ No	☐ Don't know

Tobacco:

Current smoker: ☐ Yes ☐ No Amount /day _____

Previous smoker ☐ Yes ☐ No Amount/day_____ Date ceased _____

Alcohol:

Current Drinker ☐ Yes ☐ No Amount /day _____

Previous Drinker ☐ Yes ☐ No Amount/day___ Date ceased _____

Other Substances: ☐ Yes ☐ No

If yes, please give details _____

CURRENT FUNCTIONAL ABILITIES:

(Please circle all those that are appropriate)

Expressive Communications: smiles/vocalises/points or gestures/signs or uses symbols/words/phrases/sentences/articulation problems

Comprehension: no understanding of speech/understands one part command/understand two part commands (details) _____

_____

Mobility: immobile/rolls/crawls/walks with aid/walks unaided/operates wheelchair

Fine motor: reaches/grasps/holds/transfer/manipulates/none of these

Eating: tube fed/fed by others/feeds with assistance/feeds independently

Bathing: fully dependent/able with assistance/able with supervision/independent

Toileting: incontinent of bladder/incontinent of bowel/requires supervision/continent of bladder/continent of bowel

Community living skills: (e.g. shopping, banking) ☐ Yes ☐ No

(Details) _____

_____

Travels independently: ☐ Yes ☐ No

(Details) _____

Domestic Skills: (e.g. cooking, cleaning) ☐ Yes ☐ No

(Details) _____

Literacy Skills: ☐ Yes ☐ No

(Details) _____

Any deterioration in skills or memory? ☐ Yes ☐ No

(Details) _____

_____

Eating Problem/Diet:

Chewing Difficulty: ☐ Yes ☐ No

Swallowing Difficulty: ☐ Yes ☐ No

Chokes when eating or drinking: ☐ Yes ☐ No

Regurgitates food or liquids: ☐ Yes ☐ No

(If "yes" to any of the above, please give details)

_____

_____

Food Consistency: ☐ Puree ☐ Soft ☐ Cut up ☐ Normal

Any special Diet? ☐ Yes (describe) ☐ No

_____

Sleep:

Sleeps through the night: ☐ Yes ☐ No

Day time Sleepiness: ☐ Yes ☐ No

Snores: ☐ Yes ☐ No

Details of any other sleep problems:

_____

_____

Physical Activity:

Regular Physical activity? ☐ Yes ☐ No

Type(s) of activity _____ Hours/week _____

(Details) _____

Is the activity ☐ Gentle ☐ Medium ☐ Vigorous

SOCIAL HISTORY:

Current Residence:

☐ Independent (sole)

☐ Independent (share)

☐ Family Home

☐ Group Home (DADHC)

☐ Group Home (other)

☐ Boarding House/Hostel

☐ Large Residential

Name of the accommodation/support agency:

_____

Approximate date of arrival at the current residence (if not family home) _____

If in a group home or hostel:

Number of other residents ____

Level of supervision:

☐ 24 hours (waking shift) ☐ 24 hours (sleeping shift)

☐ Other (details) _____

Work/day placement (1) _____ Hours/week _____

Work/day placement (2) _____ Hours/week _____

Other regular activities (hours/week) _____

Favourite leisure activities _____

Friendships _____

Last Holiday _____

Frequency of family contact _____

Date of last family contact _____

Respite care ☐ Yes ☐ No

If yes, name of the agency for respite care _____

How often you get respite _____

Future Accommodation Plans _____

_____

_____

Professional	Name	Date last seen	Reason for consultation & Outcome
Dentist			
Dermatologist			
ENT/Audiologist			
Gastroenterologist			
Geneticist			
Neurologist			
Ophthalmologist			
Orthopaedic			
Occupational Therapist			
Paediatrician			
Physiotherapist			
Psychiatrist			
Psychologist			
Rehab. Specialist			
Speech therapist			
Others			

This section needs to be completed by the family (if available). If the family is not available, please provide the reason: _____

FAMILY HISTORY:

Order in the family (e.g. eldest, 2nd, 3rd) _____

Consanguinity (are the parents related eg cousins): ☐ Yes ☐ No

Has any genetic advice been given? ☐ Yes ☐ No

(If "yes" please specify) _____

Mother: Name _____ **D.O.B.** _____

Health _____

Occupation _____

Father: Name _____ **D.O.B.**_____

Health _____

Occupation _____

Siblings:

Name	DOB (Age)	Health

Maternal Grandmother: Age: ____ **Maternal Grandfather:** Age: _____

Health _____

Paternal Grandmother: Age: ___ **Paternal Grandfather:** Age: _____

Health _____

Spouse/Partner: (Age) _____Health _____

Children: (Ages/Health) _____

Family history: (Please give details)

☐ Heart Disease _____

☐ High Blood Pressure _____

☐ Diabetes _____

☐ Cancer _____

☐ Intellectual disability/learning problem _____

☐ Depression/other mental health problem _____

☐ Other health problems _____

Birth History:

Assisted Conception: (e.g. fertility drugs,IVF,GIFT) ☐ Yes ☐ No

(Details) _____

Mother's age at birth _____ Father's age at birth _____

Problems during pregnancy ☐ Yes ☐ No ☐ Don't know

(Details) _____

Gestation (at how many weeks was the baby born) _____ weeks

Problems during labour ☐ Yes ☐ No ☐ Don't know

Was the delivery: ☐ normal vaginal delivery

☐ by forceps

☐ by vacuum extraction

☐ by caesarean section

Where was the baby born (hospital/home)? _____

Birth Weight _____ kg Apgar score _____

Was the baby well after birth? ☐ Yes ☐ No ☐ Don't know

(Details) _____

How many days after birth was the baby discharged home? _____

Were there any problems with the baby in the first year of life? (e.g. feeding/sleeping/crying) ☐ Yes ☐ No ☐ Don't know

(Details) _____

Development:

At what age did s/he first,

smile: _____ sit: _____ walk: _____ say words _____

speak sentences: _____

At what age were developmental problems first diagnosed? _____

Where was it done? _____

What tests were done? _____

EARLY INTERVENTION / EDUCATION

Intervention/School	Commenced	Ceased	Comments

PAST EMPLOYMENTS/DAY PLACEMENTS

Name of Service	Commenced	Ceased	Comments

PAST RESIDENTIAL PLACEMENTS

Name of Service	Commenced	Ceased	Comments

DOCUMENTS CHECK LIST

Please make sure that you send us back the following documents before the appointment.

☐ Specialist's referral with results of complete physical examination and blood tests

☐ Past Specialist's report

☐ Brain scan results if appropriate (films and reports)

☐ Behaviour intervention plan **OR** comprehensive report from service psychologist/key worker

☐ Discharge summaries from previous hospital admissions (if any)

☐ Reports from other disability services assessments

☐ Questionnaire(s)