

DIS Reference Number:

Patient Details: Name: Address:	Preferred Phone Number  Date of Birth
Legal Guardian details (if under 16) Name: Address:	Male <input type="checkbox"/> /Female <input type="checkbox"/>
Ethnicity: Australian <input type="checkbox"/> Australian Aboriginal <input type="checkbox"/> Australian South Sea Islander <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Migrant/Refugee <input type="checkbox"/> Nationality: _____	

Presenting Mental Health issues (include alcohol and other drugs, smoking status)

Current Medications:

Any other Services that patient already has or may need:

Permission to give and obtain information

I \_\_\_\_\_ understand that I give consent to my contact details being referred to WSS and that they will contact me by phone or letter

Patients Declaration Signature: \_\_\_\_\_ Date: \_\_\_\_\_

GP Signature: \_\_\_\_\_ Date: \_\_\_\_\_

GP Details: Name: Address:	Contact Phone Number:  Fax Number:
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