DOCTOR'S STAMP	DOCTOR'S STAMP

Confidential

TO OKONGUARRI PSYCHOTHERAPEUTIC CENTRE

Please admit the under-mentioned patient to your facility

PATIENT'S FULL NAME	
ID NUMBER/DATE OF BIRTH	
MEDICAL AID	
MEMBER NUMBER	
CONTACT NUMBER	

PSYCHIATRIC DIAGNOSIS

AXIS I: Clinical Diagnosis e.g. Major Depressive episode **In case of MDD, indicate score on a depression scale**	
AXIS II: Personality type or Intellectual Disorder if applicable, if not defer	
AXIS III: General medical condition if applicable e.g. Diabetes2	
AXIS IV: Psychosocial and environmental e.g. poor support by spouse	
GAF	

PRESENTING SYMPTOMS

RISK FACTORS

TREATMENT HISTORY BY GP (*including vitals)* AND/OR PSYCHOLOGIST

Medication	Dosage/Quantity	
	Existing	Proposed
Client Psychiatric Rx		
Client Chronic/other Rx	**Dosage/Quantity**	
	Existing	Proposed

FURTHER COMMENTS

Proposed date of admission	
Proposed Length of stay	
Prognosis with in-house treatment	

Urgency of admission: ASAP | URGENT | VERY URGENT

_____ _____

REFERRING MEDICAL PRACTITIONER

REFERRING PSYCHOLOGIST