|  |  |  |
| --- | --- | --- |
| **Date of Referral** |       | [ ]  A Mental Health Plan or Child Health & Wellbeing Plan has been completed (if applicable) |
| **Service Needed:** | [ ]  Counselling Services [ ]  Social Work services |
| **Referrer Name:** |       |
| **Practice/Organization Name of Referrer:** |       |
| **Practice Address** |       | **Postcode** |       |
| **Priority Groups** | [ ]  Young person (12-25) [ ]  Homeless/at risk [ ]  Remote [ ]  CALD (Culturally & Linguistically Diverse)[ ]  Suicide prevention [ ]  Carer with Mental illness [ ]  Perinatal [ ]  Aboriginal/Torres Strait Islander |
| **Stepped Care program** | [ ]  General [ ]  Child [ ]  Suicide Prevention Service (SPS) [ ]  Extreme climactic events |
| **Patient Risk Assessment**  | **If you answer YES to any of these, please consider a referral to Mental Health Triage - Latrobe Regional Hospital (1300 363 322)** Suicide Ideation? [ ]  Yes [ ]  No Do they have access and means? [ ]  Yes [ ]  NoDo they have a plan? [ ]  Yes [ ]  No Is there history of attempts? [ ]  Yes [ ]  NoAre they at risk to others? [ ]  Yes [ ]  No **Has recent behavior of your partner or family member towards you made you feel frightened? Or Are you afraid of your partner or a family member?**[ ]  Yes [ ]  No \*recent defined as in the last 3 months  |

**Client Details**

|  |  |
| --- | --- |
| **Name** | Surname:   |
|  | Given Name:  |
| **Address:** |  |
| **Mobile Number:****Landline number:** |  |
| **Gender**  | [ ] Male  [ ] Female [ ] Intersex [ ] Gender Diverse [ ] Transgender | **Date of Birth**(dd/mm/yyyy)**Postcode:**  |       |
|  |  |  |       |
| **Does the Client live on their own?** | [ ]  Yes[ ]  No |
| **Main language spoken at home** | [ ] English[ ] Cantonese[ ] Mandarin[ ] Vietnamese | [ ] Italian[ ] Greek[ ] Arabic |
|  | [ ] Other (*please specify*):       |
| **How well does the client speak English?** | [ ] Very Well[ ] Not Well[ ] Unknown | [ ] Well[ ] Not At All |
| **Is the client of Aboriginal and or Torres Strait Islander origin?**  | [ ] Aboriginal[ ] Torres Strait Islander[ ] Aboriginal & Torres Strait Islander[ ] Neither Aboriginal or Torres Strait  Islander |
| **Has the client received mental health care before?** | [ ] Yes – for the current problem [ ] Yes – for a different problem [ ] No [ ] Unknown |
| **Diagnosis:****Medications:** |  |
| **Other conditions/symptoms that may influence client outcomes and participation:** |  |
| **Please provide further details on the next page. It helps our service if as much detail as possible is provided within the referral.** |

|  |
| --- |
| Reason for referral: |

**REFERRAL INFORMATION:**