|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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  No  Do they have a plan?  Yes  No Is there history of attempts?  Yes  No  Are 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:**