Referral Form

Surname:

Given name(s):

Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to disclose

Date of birth:

Aboriginal:	☐ Yes	☐ No	☐ Prefer not to disclose
Torres Strait Islander:	☐ Yes	☐ No	☐ Prefer not to disclose

Address:

Contact Details

☐ Phone	Enter phone number	Can leave message?	☐ Yes ☐ No
☐ Email	Enter email address	Can leave message?	☐ Yes ☐ No

Preferred method of contact: ☐ Phone ☐ Text ☐ Email

Alternative contact / relationship: Enter name/relationship Phone Enter phone number

What would you / your family member like help with?

Primary reason(s) for referral identified by service provider

(please tick no more than 3 reasons)

☐ Mental Health concerns ☐ Alcohol & drug use ☐ Accommodation support ☐ Job support
☐ Relationship concerns ☐ Family & carer support ☐ Support with socialisation/engaging in activities
☐ Support coordinating services involved in care/navigating service system
☐ Other (please specify):

What service do you / the person being referred want support from?

Service: Choose an item.

Location: Choose an item.

Are there known risks or things we should be alerted to?

☐ Suicide ☐ Self-harm ☐ Harm to others ☐ Withdrawal from alcohol or drugs
☐ Homelessness ☐ Domestic Violence ☐ Environmental ☐ Legal issues
☐ Other:

If risk issues are present describe:

If this referral is considered to be an immediate and high risk of harm to self or others it MUST be treated as urgent and a referral made to AccessLine via 1800 800 944*

*Where referrals currently go directly to Drug and Alcohol Services this practice should continue using this form

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What other services are you/ the person being referred currently receiving support from?	
Service name/service type	Record contact details or other relevant information

Is there any other relevant information that you would like to share?

(E.g. NDIS package; English not first language; interpreter required; formal mental health diagnosis; mental health treatment plan; what you hope to achieve from being referred to this service; recovery goals; background information; etc.)

Referrer to complete

Name:

Organisation/Practice/Carer:

Phone: Email: Fax:

Signature: (Optional) Date: / /

Alternative contact: Phone:

Written Consent

☐ I am aware that this referral is being made and agree to information in this form being shared for the purpose of the referral. I also understand that I can withdraw my consent for referral at any time.

☐ I am making this referral on behalf of someone else. I have consent from the person for whom I am making the referral.

☐ I am making this referral on behalf of someone else for whom I am the appointed guardian / nominated carer.

Verbal Consent

☐ I have discussed this referral with the consumer and have obtained their verbal consent to make the referral. I am satisfied that informed consent has been obtained.

Signature: (Optional) Print Name: Date: / /

Referral acknowledgment: to be completed by the agency in receipt of referral

Name:	Position:	
Organisation:	Phone:	
Email:	Fax:	Date: / /

Status of referral ☐ Accepted ☐ Not accepted *(note reason & suggested alternative)*

☐ Placed on wait list *(please indicate anticipated wait time)*

Contact person for further information *(if not same as above)*: