Provisional Referral

**Client Details Date:**

|  |  |
| --- | --- |
| *Full Name* |  |
| *Date of Birth* |  |
| *Phone* |  |
| *Email* |  |
| *Home Address* |  |
| *Aboriginal and/or Torres Strait Islander descent*  |  |
| *Main Language**Is interpreter required?* |  |
| *Emergency Contact* |  |
| *Emergency Contact Relationship* |  |
| *Emergency Contact details* |  |
| *GP Name:**Surgery:* |  |
| *Current Mental Health Treatment Plan?**NDIS funding?* |  |
| *Are they aware of this referral?* |  |

**Referrer Details**

|  |  |
| --- | --- |
| *Referrer Name* |  |
| *Phone Number**Fax Number* |  |
| *Email* |  |
| *Organisation* |  |
| *Role* |  |

|  |  |
| --- | --- |
| *Main presenting concerns* |  |
| *Goals and expected outcomes* |  |
| *Who else is involved – agencies, support workers, carers*  |  |

**Referral Information**

**Risk Assessment**

|  |  |
| --- | --- |
| *Is there a risk to themselves?* *Are there thoughts of wanting to end their lives or self harming?*  |  |
| *Are there thoughts of harm towards others?* |  |

**Is there anything else that we need to be aware of?**

***Thank you***

***Completed referrals can be emailed to*** ***tash@behindthewaves.com.au*** ***or posted to PO Box 156, SEAFORD SA 5169***