**Mental Health Recovery Team Referral Form**

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| **Referral details** |
| **Referral Date** | \_\_\_\_\_/\_\_\_\_/\_\_\_\_\_ |
| **Referral Type** | 🞏 Self-Referral 🞏 Carer / Natural Support 🞏 Service Provider  |
| **Is the client aware of and in agreement for this referral to be made?**  | 🞏 YES 🞏 NO  |

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| **Personal Information** |
| **Given Name** |   | **Surname** |   |
| **Preferred Name (If different from given name):**  |   | **Date of Birth:** |  / /  |
| **Country Of Birth** |   |
| **Please tick:** | 🞎 Aboriginal | 🞎 Torres Strait Islander | 🞎 Aboriginal & TSI | 🞎 Non-Aboriginal |
| **Language Group** |   |
| **Gender Identity** | 🞎 MALE 🞎 FEMALE | 🞎 OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Address** |   |
| **Suburb / Town** |   | **Postcode** |   |
| **Telephone (Home)** |   | **Telephone(Work)** |   |
| **Telephone(Mobile)** |   | **Email:** |   |
| **Preferred Contact Method:** | 🞎 Phone Home | 🞎 Phone Work | 🞎 Phone Mobile | 🞎 Email |
| **Best time to contact:** | 🞎 Morning | 🞎 Afternoon | 🞎 Evening | 🞎 Anytime |
| **Client Preferences (e.g gender of worker)** |   |
|   |
| **Will the client attend with a family member, significant other or support worker?** | 🞏 YES 🞏 NO🞏 UNSURE |
| **Other Services involved:** |   |
| **Reason for Referral** | 🞏 Psychology 🞏 Mental Health Social Work 🞏 Narrative Practitioner 🞏 Counselling |
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| **background information** |
| **If applicable, a copy of any current risk assessments and / or safety plans must be sent with the referral** |
| 🞏 Current Risk Assessment attached | 🞏 Safety Plan Attached |

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| **Tick if applies** | **Social, Legal, Health and Welfare Service Priority Considerations** | **Details**  |
|  | Suspected or diagnosed mental health condition |  |
|  | Homeless or at risk of homelessness |  |
|  | Currently residing at a psychiatric or residential mental health facility |  |
|  | Currently in prison, on parole, or under Corrections / judicial management |  |
|  | Currently a primary caregiver for children |  |
|  | Currently living with a disability (e.g. intellectual, acquired brain injury, physical, developmental) |  |
|  | Experiencing, or recently, experienced domestic and family violence(e.g. physical, emotional, financial, sexual, social, psychological) |  |

I , \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_have been given Verbal / Written (please circle) consent for this referral to be made on their behalf, including the personal and health information provided.

**By agreeing to this referral, the client consents to having the details on this form stored in Nunkuwarrin Yunti’s client file information system.**

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| --- | --- | --- | --- |
| Staff Signature |  | Date |  |

***For written consent please ask client to sign and date below:***

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| --- | --- | --- | --- |
| Client Signature |  | Date |  |

**PLEASE FAX TO: 8223 7658 Phone Enquiries:** 8392 3500

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| **Delivering Mental Health Recovery Services from:** |
| 28-30 Brady Street Elizabeth Downs SA 5113  | 182-190 Wakefield StreetAdelaide SA 5000 | 17 Beach RoadChristies Beach SA 5165 |