**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:***

|  |  |  |  |
| --- | --- | --- | --- |
| 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 Street  Adelaide SA 5000 | 17 Beach Road  Christies Beach SA 5165 |