**REFERRAL FORM**

**PRIVACY NOTICE:** Anglicare Central Queensland is collecting the personal information you supply on this form for the purpose of providing a service in response to a request. Your personal details will not be disclosed to any other person or agency external to Anglicare Central Queensland without your consent unless required or authorised by law.

**Referral Out  Referral In Send to:** intakementalhealth@anglicarecq.org.au

|  |  |  |
| --- | --- | --- |
| Healthy Minds  **Referrals: CQ & CWHHS Mental Health ONLY**  18+ Severe & Persistent Individual Recovery Program | National Psychosocial Support  **Area: Central Queensland**  18+ Severe & Persistent Mental Illness  Individual & Group Recovery Program  Access Request NDIS | Warm Line  **Area: Central Highlands ONLY**  After hours support Wed-Sat  For vulnerable people attempted or at high risk of suicide |
| **\*People with NDIS Plans & active Commonwealth participants are ineligible for Healthy Minds & NPS Programs** | | |

**Referral sent from**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name |  | | Organisation |  |
| Role |  | | | |
| Phone number |  | | Date of referral |  |
| Email |  | | | |
| Availability for collaborative care planning | |  | | |

**Completed referral form to be sent to**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Organisation |  |
| Role |  | | |
| Phone number |  | Date of referral |  |
| Email |  | | |

**Participant’s details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name |  | | | |
| Address |  | | | |
| Date of birth |  | Gender |  | |
| Phone |  | Mobile |  | |
| Consent for referral | Yes  No | No of children |  | |
| Cultural background | Indigenous  TSI  CALD  Other | | | |
| Additional support for special needs required | Cultural  Physical  Intellectual  Communication  Other  Please specify: | | | |
| Current Diagnosis | Persistant  Episodic | | | |
| Current Medications |  | | | |
| Progress Notes Plan | Yes  No | Stable Accomdation | | Yes  No |

**Reason for referral**

|  |  |
| --- | --- |
|  | |
| Co-morbidities |  |

**Any risk factors to be considered and strategies already in place**

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| --- |
|  |

**Office use only**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Referral accepted | Yes  No | | Date |  |
| Reason for declined referral | |  | | |
| Staff member name |  | | Service and location |  |