**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 ProgramAccess 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 [ ]  OtherPlease 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 |  |