Outreach Referral Form

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| **Referrer Details (self-referral, medical practitioner, family member, support worker, case manager).** |
| Date of Referral: |  |
| Name: |  |
| Agency/Position/Relationship to the client:  |  |
| Phone Number: |  |
| Email Address: |  |
| **Client Details:**  |
| Name: |
| Reason for referral: |
| Phone Number: |
| Email Address:  |
| Gender: | Date of Birth: |
| Address:  |
| Aboriginal or Torres Strait Islander origin?  |
| Is an interpreter required? Yes/No If Yes what language?  |
| **Additional Health Information:** |
| Mental Health Concerns and reason for referral?  |
| Previous Mental Health History: |
| Current medications:  |
| Mental Health Diagnosis (if known):  |
| Are there any other health needs Richmond Fellowship Tasmania needs to be aware of?  |
| Are there any current or previous risks such as self-harm, violence or illness? |
| **Goals and Supports** |
| What goals does the client have and what are the expected supports?  |
| **Other Services** |
| Please list any other services involved including current GP, Community Supports, Case Managers, Psychiatrists, psychologists: |
| Name: | Organisation: | Phone: | Support Received:  |
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|  |  |  |  |
| Signed: | Date: |
| Name: |  |