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: | |  | |