CLIENT REFERRAL FORM – PRIVATE & CONFIDENTIAL

Client Consent and Privacy

All services and supports provided by Bridges Health & Community Care are voluntary. Please confirm that you have client consent for this referral by placing a cross in the relevant box. All information is handled in accordance with our privacy policy available at https://www.bridgeshcc.org.au/privacy-policy.

☐ Written Consent ☐ Verbal Consent ☐ N/A – Self Referral

Client Personal Details

Name: Date of Birth:

Address:

Sex: ☐ Male ☐ Female

Gender: ☐ Man or Male ☐ Woman or Female ☐ Non-binary

☐ Use a different term (please specify): _____ ☐ Prefer not to answer

Does the person identify as Indigenous? ☐ Y ☐ N If Yes? ☐ Aboriginal ☐ Torres Strait Islander ☐ Both

Country of Birth: Preferred Language: Translator Required ☐ Yes ☐ No

Please provide details of how the client wishes to be contacted by Bridges to arrange an appointment – you may place a X in multiple boxes

☐ Phone # Notes: Can we leave a message on this phone? ☐ Yes ☐ No

Most convenient time to call If mobile, can we send an SMS? ☐ Yes ☐ No

☐ Email: ☐ Letter to home address

☐ Letter to alternate address (please provide details):

Services Required – you may place a cross in multiple services

☐ **Psychology**	☐ **Fraser Coast**			
☐ **Drug, Alcohol Rehabilitation & Treatment Service**	☐ **Bundaberg**	☐ **Fraser Coast**	☐ **North Burnett**	☐ **Gladstone**
☐ **Family Alcohol & Drug Information & Support (Breakthrough for Families BFFQ)**	☐ **Bundaberg**	☐ **Fraser Coast**	☐ **North Burnett**	
☐ **Choose a Better Life (NDIS services)**	☐ **Bundaberg**	☐ **Fraser Coast**	☐ **Rockhampton**	
☐ **Psychosocial Support / Individual Recovery**	☐ **Bundaberg**	☐ **Fraser Coast**	☐ **North Burnett**	☐ **Gladstone**
Community-based Mental Health				
☐ **Stepped Care Stream 4 Complex Needs**	☐ **Bundaberg**	☐ **Fraser Coast**		
☐ **Child & Family Mental Health Support**	☐ **South Burnett**		☐ **North Burnett**	
☐ **Youth Support**	☐ **North Burnett**			

External Intake Services Required

For Stepped Care Stream 4 Complex Needs programs, referral through the Head to Health Intake system is required. Do you/your client consent for this information to be passed on to Head to Health? ☐ Yes ☐ No

Reason for Referral - Other Information Relevant to Treatment OR Support Needs - *Please attach any supporting documentation.*

Presenting Mental Health Issue E.g. Diagnosis, issue – anxiety, depression etc.

Drug and/or Alcohol Issue E.g. alcohol, cannabis

Other Health Issues or Psychosocial Factors E.g. medical factors, other diagnosis, homelessness, stress, social situation

Risk Factors E.g. Harm to self or others, suicide risk, vulnerability

Choose a Better Life (NDIS) – specify other relevant information E.g. disability type, assessment needs etc.

Do you have consent to share client's full NDIS Plan? ☐ Yes ☐ No ☐ N/A – Self Referral Is a copy attached? ☐ Yes ☐ No

Person Making Referral

Name:		Date of Referral:
Organisation:		
Fax:	Phone:	Email:
Signature:		