

## 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 # \_\_\_\_\_ Most convenient time to call: \_\_\_\_\_ Can we leave a message on this phone?  Yes  No  
 Notes: \_\_\_\_\_ 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

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Psychology   | <input type="checkbox"/> Fraser Coast         |  |
| <input type="checkbox"/> Drug, Alcohol Rehabilitation & Treatment Service                             | <input type="checkbox"/> Bundaberg            | <input type="checkbox"/> Fraser Coast <input type="checkbox"/> North Burnett |
| <input type="checkbox"/> Family Alcohol & Drug Information & Support (Breakthrough for Families BFFQ) | <input type="checkbox"/> Bundaberg            | <input type="checkbox"/> Fraser Coast <input type="checkbox"/> North Burnett |
| <input type="checkbox"/> NDIS Service   | <input type="checkbox"/> Bundaberg            | <input type="checkbox"/> Fraser Coast <input type="checkbox"/> Rockhampton   |
| <input type="checkbox"/> Psychosocial Support / Individual Recovery Community-based Mental Health     | <input type="checkbox"/> Bundaberg            | <input type="checkbox"/> Fraser Coast <input type="checkbox"/> North Burnett |
|   | - Referrals via Hospital Health Services only |  |
| <input type="checkbox"/> Child & Family Mental Health Support   | <input type="checkbox"/> South Burnett        | <input type="checkbox"/> North Burnett                                       |
| <input type="checkbox"/> Youth Support  | <input type="checkbox"/> North Burnett        |  |

**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: