

CLIENT REFERRAL FORM – PRIVATE & CONFIDENTIAL

Client Consent and Privacy – PLEASE READ...			
All services and supports provided by Bridges Health & Community Care are voluntary. Please confirm that you have client consent for this referral, AND your client agrees that this document and their details, will be shared with a local panel of providers representing <i>Qld Police Service, Qld Education and Qld Youth Justice Department</i> for final approval into BRIDGES Regional Reset Program. To confirm consent, please select the relevant consent box. All information is handled in accordance with our privacy policy available at https://www.bridgeshcc.org.au/privacy-policy .			
<input type="checkbox"/> Written Consent	<input type="checkbox"/> Verbal Consent	<input type="checkbox"/> Self-Referral	
Have you obtained parental/guardian consent? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Client Personal Details			
Name:		Date of Birth:	
Address:			
Sex:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Gender:	<input type="checkbox"/> Boy or Male	<input type="checkbox"/> Girl or Female	<input type="checkbox"/> Non-binary
	<input type="checkbox"/> Use a different term (please specify):		<input type="checkbox"/> Prefer not to answer
Does the person identify as Indigenous?	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes? <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both	
Country of Birth:	Preferred Language:	Translator Required <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please provide details of how the client wishes to be contacted by Bridges to arrange an appointment – you may select multiple boxes			
<input type="checkbox"/> Phone Youth:	<input type="checkbox"/> Phone Parent/Guardian:	Can we leave a message on this phone?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Most convenient time to call:		If mobile, can we send an SMS?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Email:		<input type="checkbox"/> Letter to home address	
<input type="checkbox"/> Letter to alternate address (please provide details):			
Location for Services Required			
<input type="checkbox"/> Bundaberg & District	<input type="checkbox"/> Fraser Coast – Hervey Bay	<input type="checkbox"/> Fraser Coast – Maryborough	<input type="checkbox"/> North Burnett
Reason for Referral – E.g. Petty Crime, School disengagement, Anti-Social Behaviour, at risk of Youth Justice, Police or Court Involvement - <i>Please attach any supporting documentation.</i>			

Additional Information Relevant to Treatment OR Support Needs, E.g. Family involvement, Child Safety involvement, Barriers etc.

Please include any pro-social activities or strategies already underway

Specify if any Presenting Mental Health Issue E.g. Diagnosis, issue – anxiety, depression, bullying, trauma etc.

Specify if any Drug and/or Alcohol Issue E.g. alcohol, cannabis, including family substance use.

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

Specify if any Risk Factors E.g. Harm to self or others, suicide risk, vulnerability, domestic violence

Have you completed the Screening Tool for Regional Reset? If yes, please attach with this form.

Person or Service Provider Making Referral

Name:

Date of Referral:

Phone / Fax:

Email:

Signature:

Organisation:

Email completed form to regionalreset@bridgeshcc.org.au

Postal address: PO Box 4, Bundaberg 4670

Phone 1300707655 – Fax 4151 6186 – email regionalreset@bridgeshcc.org.au – www.bridgeshcc.org.au

ABN 45 402 866 190 – ACN 632 275 275