

## 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 tick 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 # \_\_\_\_\_ 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 / Counselling  Bundaberg  Fraser Coast  North Burnett

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  Gladstone  Rockhampton

Psychosocial Support / Individual Recovery  Bundaberg  Fraser Coast  North Burnett  Gladstone  
 Community-based Mental Health  Rockhampton

Stepped Care Stream 4 Complex Needs  Bundaberg  Fraser Coast

Child & Family Mental Health Support  South Burnett  North Burnett

Youth Support  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		

Shop 4, 130 Bourbong Street, Bundaberg Central – PO Box 4, Bundaberg 4670  
Phone 1300707655 – Fax 4151 6186 – email [referrals@bas.org.au](mailto:referrals@bas.org.au) – [www.bridgeshcc.org.au](http://www.bridgeshcc.org.au)  
ABN 45 402 866 190 – ACN 632 275 275