Mental Health Referral Form

Boab Health Services

Our mental health service supports client with **mild** to **moderate** mental health conditions.
Clinical responsibilty lies with the referrer until a clinical services commences.
Once complete, send this referral and all accompanying documents to one of the following:
reception@boabhealth.com.au | MMEx Secure Messaging: **Boab Counselling |**Health Link EDI: **boabheal |** Fax: **08 9192 7999**

CLIENT DETAILS

Date of Referral	**Title**	**First Name**	**Middle Name(s)**

Surname	**Preferred Name**	**Date of Birth**

Sex: ☐ Male ☐ Female ☐ Other | **Gender**: ☐ Male ☐ Female ☐ Non-binary

Is the client of Aboriginal and / or Torres Strait Islander origin?
☐ Aboriginal Only ☐ Torres Strait Islander only ☐ Both Aboriginal and Torres Strait Islander ☐ Neither ☐ Not stated

Country of Birth ☐ Aus ☐ Other	**Interpreter Required?** ☐ Yes ☐ No	**Main Language Spoken At Home** ☐ English ☐ Other

Complete the client's contact detail and choose their preferred method of communication

☐ **Mobile**	☐ **Email**	☐ **Telephone**

Residential Address	**Suburb / Community**	**State**	**Postcode**

Postal Address (If different from above) PO Box, Parcel locker	**Suburb / Community**	**State**	**Postcode**

Healthcare Card ☐ Yes ☐ No | **NDIS Participant** ☐ Yes ☐ No

Medicare card number ☐☐☐☐☐☐☐☐☐☐ **Ref No.** ☐ **Expiry** ☐☐ / ☐☐☐☐

Maritial Status: ☐ Married / Defacto ☐ Divorced / Seperated ☐ Single ☐ Never Married ☐ Widowed
Employment Status: ☐ Full Time ☐ Part-time ☐ Unemployed ☐ Not in the work force
Accomodation Status: ☐ Own house / rental ☐ Short-term / emergency ☐ Staying with friends / family ☐ Homeless

Under 18 Client: *Parent or Guardian / Carer / Emergency Contact*

Name	**Contact Number**	**Relationship to client**

REFERRAL SOURCE

Name	**Phone**
Role	**Email**
Organisation	**Address**

SERVICE REQUIRED

☐ **Low Intensity Therapy**	Short term intervention for people experiencing **mild** mental health concerns or symptoms (up to 3 sessions).
☐ **Adult Therapy**	Psychological therapy or counselling for adults aged 18 years and above with a **moderate**, mental health condition (up to 10 sessions).
☐ **Child / Young person therapy**	Therapy and support for children and young people to address common mental health issues.
☐ **Clinical Care Coordination**	Case management support (in collaboration with GP) for clients with a severe mental illness.
☐ **Other**	

REASON FOR REFERRAL

Provide details or presenting concerns:

Is this referral to support suicide ideation or recent history of suicide attempt? ☐ Yes ☐ No

Specify if there is a principal mental health diagnosis:	**If applicable, list any additional mental health diagnosis:**

Does the client have a mental health care plan?

☐ Yes ☐ No

Additonal relevant medical and social history inc the risk of harm to self or others:

Please indicate if the client is taking any of the following medications?

☐ Antipsychotics ☐ Anxiolytics ☐ Hypnotics/Sedatives ☐ Antidepressants ☐ Psychostimulants/Neotropics

Provide some relevant history on the client's situation inc family history, social supports, and cultural considerations

To complete this referral please confirm the below:

☐ I have obtained consent from the client / legal guardian for the referral and they have agreed to provide their personal health information to Boab Health Services.

Please ensure the following are included where necessary:

☐ The K10+, SDQ, GPMHCP, MSE or any other assessment tools and relevant documents are attached.

☐ The client and or carer / guardian has consented to the referral and has agreed for us to contact them for an appointment.