

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

- | | | | | |
|---|--|---------------------------------------|--|--|
| <input type="checkbox"/> Psychology / Counselling | <input type="checkbox"/> Bundaberg | <input type="checkbox"/> Fraser Coast | <input type="checkbox"/> North Burnett | |
| <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"/> Gladstone |
| <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"/> Choose a Better Life (NDIS services) | <input type="checkbox"/> Bundaberg | <input type="checkbox"/> Fraser Coast | <input type="checkbox"/> Gladstone | <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 | <input type="checkbox"/> Gladstone
<input type="checkbox"/> Rockhampton |
| <input type="checkbox"/> Stepped Care Stream 4 Complex Needs | <input type="checkbox"/> Bundaberg | <input type="checkbox"/> Fraser Coast | | |
| <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		

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