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 # 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** Community-based Mental Health	☐ **Bundaberg**	☐ **Fraser Coast**	☐ **North Burnett**	☐ **Gladstone** ☐ **Rockhampton**
☐ **Stepped Care Stream 4 Complex Needs**	☐ **Bundaberg**	☐ **Fraser Coast**		
☐ **Child & Family Mental Health Support**	☐ **South Burnett**		☐ **North Burnett**	
☐ **Youth Support**	☐ **North Burnett**			

External Intake Services Required

For Psychosocial Support and Stepped Care Stream 4 Complex Needs programs, referral through the Head to Health Intake system is required. Do you/your client consent for this information to be passed on to Head to Health?

☐ **Head to Health - Psychosocial Support** ☐ **Head to Health - Stepped Care Stream 4 Complex Needs**

Reason for Referral - Other Information Relevant to Treatment OR Support Needs - *Please attach any supporting documentation.*

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

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		