**Forward completed Referral via Medical Objects to: *Head to Health Gold Coast Referrals***

**or Fax 07 3186 4099**

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| By consenting to this referral, the person is consenting to the sharing of their personal information. The information contained in the referral is used by the Head to Health Phone Service to: (1) deliver assessment and referral services, (2) for monitoring, aggregate reporting and evaluation purposes to improve quality and access to care. This information will be passed on to the recommended provider who will contact the person.Please indicate the information in this form has been discussed with, and provided to, the patient:[ ] Yes [ ] No**Patient or Parent/Guardian/Carer consents to referral?** [ ]  Yes [ ]  No**Referrer consents to the collection and storage of referrer details on internal database?** [ ]  Yes [ ] No |
| **REFERRER DETAILS** | Date of Referral |  |
| Title & First Name |  | Last Name |  |
| GP Practice/Organisation |  |
| Address |  |
|  |
|  | Post Code |  |
| Phone No. |  | Email |  |
| Fax No. |  |  |  |

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| **PATIENT / CLIENT DETAILS** |
| First Name |  | Date of Birth |   |
| Last Name |  | Preferred Name |  |
| Address |  |
|  |
|  | Post Code |  |
| Phone No.  |  | Email |  |
| Health Care/Pension Card | [ ]  Yes [ ] NoExpiry date: | Gender | [ ]  Male [ ]  Female [ ]  Other |
| Aboriginal or Torres Strait Islander status: |  [ ]  Aboriginal [ ]  Torres Strait Islander [ ]  Both [ ]  Neither  |
| Culturally & Linguistically Diverse (CALD) | [ ]  Yes [ ] No | Is an interpreter required? | [ ]  Yes [ ] No |
| Language spoken at home |  |
| Is there a current Mental Health Treatment Plan in place? *(If yes, please attach to this referral)* | [ ]  Yes [ ] No |
| Emergency Contact Name |  | Relationship to client | [ ]  Parent [ ]  Guardian [ ]  Carer |
| Phone Number |  |  |  Other: |

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| **REFERRAL NOTES** |
| Mental health diagnosis |  |
| Medications |  |

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| **KEY GOALS (what else do we need to know to support the individual moving forward)** |
| What are the individual’s key goals, and hopes for engaging in the program? What are the individual’s strengths and support systems?Is there anything you or the individual would like us to know about how we can best meet their needs? (e.g., cultural needs; medical; medication issues; developmental, functional; living skills; social; emotional; trauma, abuse and neglect; etc.) |  |
| **IDENTIFIED AREAS OF SUPPORT REQUIRED**  |
| [ ]  | Emotional Wellbeing | [ ]  | Social Connection | [ ]  | Housing or Social Supports | [ ]  | Families & Relationships | [ ]  | Domestic Violence |
| [ ]  | Physical Health / ADLs | [ ]  | Food, Diet, or Lifestyle | [ ]  | Financial Needs & Benefits | [ ]  | Employment & Education  | [ ]  | NDIS & My Aged Care |
| **SAFETY ALERTS** - Are there any risk factors we should be aware of when visiting the home/client? For example if there is a history of aggressive behaviour?*Please tick all that apply.*  | [ ]  YES - please provide details below or attach risk assessment [ ]  NO [ ]  UNKNOWN |
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| [ ]  Risk of harm to self [ ]  Risk of harm to other [ ]  Mental Health Order[ ]  Enduring Power of Attorney [ ]  Not able to make own decision / Guardianship [ ]  Orders relating to children [ ]  Intervention Order / AVO [ ]  Triggers / Trauma |
| Please attach any plans/history | [ ]  YES – I am attaching relevant medical history and/or current treatment plans  |
| **Plus Social Clinical Care Coordination is a comprehensive, high intensity clinical support service for people age 18+ who experience the impact of severe mental illness and are not currently case-managed or accessing Gold Coast Health mental health services. Up to 26 weeks clinical care coordination and wellbeing program that is structured, recovery and goal orientated focused on creating significant improvements in quality of life, health and wellbeing.**  |