

The Way Back Support Service

Out of Hospital (OOH) Program

Referrals: 07 3539 6444
mentalhealthintake@wmq.org.au

GP Referral Form

Holistic non-clinical community mental health support for people experiencing suicidality & experiences of self-harm for up to three months.

CLIENT DETAILS

Full Name: _____

Address: _____

D.O.B: _____

Indigenous Status:

☐ Aboriginal ☐ Torres Strait Islander ☐ South Sea Islander

Gender: Male ☐ Female ☐ Other ☐

Phone: _____

Preferred Contact Method: Phone ☐ SMS ☐

REFERRAL INFORMATION

Reason for Referral:

Recent suicide attempt ☐ Recent hospital presentation (mental health) ☐ High risk/ongoing suicidality ☐

Self-Harm ☐ Risk of Harm to Self: Low ☐ Moderate ☐ High ☐ Any immediate safety concerns: Yes ☐ No ☐

GP REFERRER DETAILS

GP Name: _____ Practice Name: _____

Phone: _____ Email: _____

RELEVANT INFORMATION

Current Mental Health Diagnosis / Concerns:

Relevant History / Medications:

CLIENT CONSENT

I consent to this referral being made to
The Way Back Support Service – OOH Program.

Client Signature: _____ Date: ____/____/____

GP DECLARATION

I confirm the above information is accurate and this
referral has been discussed with the client.

GP Signature: _____ Date: ____/____/____



Please return completed form to:
mentalhealthintake@wmq.org.au
or fax to: 07 3539 6444



For urgent referrals or enquiries:
Call 07 3539 6444