# COVID 19 Recovery Service Referral

**Confirmation of eligibility criteria**
(must confirm all ☑)
☐ Resides in Gold Coast region
☐ Benefit from short-term intervention
☐ COVID related Mental Health/Wellbeing decline

**Referral Type** (☑ **at least one referral type**)
☐ COVID 19 Recovery Service – general (16 years or older)
☐ COVID 19 Recovery Service - Older People (aged over 65 years or Aboriginal and/or Torres Strait Islander aged over 55)

**Referrer Information:**

**Date of referral:**_____

**Name of referrer:**_____

**Profession:**_____

**Provider No.:** _____

**Practice name:** _____

_____

**Phone:**_____

**Fax:**_____

**Client consent:** You confirm that the person has been informed about and consented to:
☐ information on this referral form being shared with Wesley Mission Queensland, service providers involved in their care and other PHN-commissioned services when indicated
☐ the support person identified on this referral being contacted by the service provider.
☐ information on this referral being shared with Gold Coast PHN for statistical purposes.
☐ de-identified information on this referral form being shared with the Department of Health for statistical purposes.

**GP Mental Health Treatment Plan Developed**
☐Yes ☐No ☐In process of development

*Note: GPs are **not** required to attach the completed Mental Health Care Plan.*

**Client Information**
**Client full name:**_____**DOB:**_____

**Preferred name:**_____

**Gender:** ☐Male ☐ Female ☐Transgender Female (Male-To-Female) ☐Transgender Male (Female-To-Male) ☐Non-Binary ☐Other: _____

**Sexual Orientation:** ☐Straight/Heterosexual ☐Lesbian, Gay, Homosexual ☐Bisexual ☐Don't Know ☐Not Stated ☐Other: _____

**Street Address:** _____

**Suburb:** _____**Postcode:**_____

**Home Phone:** _____**Mobile:**_____
**OK to leave message?** ☐ **Yes** ☐ **No**

**Support Person name:** _____

**Support Contact:** _____**Relationship**:_____

**Ethnicity:**
☐ Australian ☐ Both Aboriginal and Torres Strait Islander ☐Aboriginal only ☐Torres Strait Islander only ☐ Other:_____

**Country of Birth**: ☐Australia ☐Other:_____

**Main Language Spoken at Home:** ☐English ☐Other:_____

**Proficiency in English:** ☐Not at all ☐Not well ☐Well ☐Very well ☐N/A (<5 years/English First language) ☐Interpreter Required:_____

**Contributing factors** (☑ all that apply)

| | |
|---|---|
| ☐Chronic disease:_____ | ☐Legal / corrections issues |
| ☐Accident / injury | ☐Alcohol or drug related problems |
| ☐Grief / loss | ☐Gambling / other addiction |
| ☐Physical Disability | ☐Trauma/abuse |
| ☐Intellectual disability | ☐Bullying and/or harassment |
| ☐Physical Health decline | ☐Divorce or separation |
| ☐Mental Health decline | ☐Cognitive decline |
| ☐Loneliness/isolation | ☐Housing |
| ☐ Carer, unpaid | ☐Other, specify: _____ |

**Reason for referral/presenting concerns (including any identified risks):**
_____
_____
_____
_____
_____

**Required service/s:**
☐ Mental Health Nursing
☐ Psychological Therapies/Counselling
☐Psychosocial Support

**Would you like someone to attend your appointments with you?** ☐ **No**
☐ **Yes (If yes, name & phone:** _____**)**

***At the completion of this referral please fax to (07) 3621 1234 or alternatively via Medical Objects secure messaging to ID RC41060000D. If you have any questions please call (07) 5625 1949.***

This service has been made possible through funding provided by the Australian Government under the PHN Program