Gold Coast
HEAD TO HEALTH

REFERRAL FORM – Head to Health Phone Service

This referral form will be used by the Head to Health Phone Service, the consumer will be contacted for an assessment to determine the most appropriate service intensity and type.

If you have completed a MHTP or used the Initial Assessment and Referral Decision Support Tool please attach with the referral.

If you require assistance completing this referral form please contact Head to Health Phone Service on **1800 595 212**

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. ☐ Y ☐ N

Patient or Parent/Guardian/Carer consents to referral? ☐ Y ☐ N

Referrer consents to the collection and storage of referrer details on internal database? ☐ Y ☐ N

Referral date:

Referrer Details

Name:	Role / Organisation:
Address:	Email:
	Phone:
	Fax:

Consumer Details

Full Name: Preferred Name:	DOB:	Gender Identity: ☐ M ☐ F ☐ Other: Pronouns:
Address: ☐ Experiencing homelessness		Postcode:
Home Ph:		Mobile Ph:
LGBTIQAP+: ☐ Y ☐ N		Health Care/Pension Card: ☐ Y ☐ N Expiry date:

Aboriginal or Torres Strait Islander status: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither

Culturally or Linguistically Diverse (CALD): ☐ Y ☐ N

Language spoken at home:

Is an interpreter required? ☐ Y ☐ N

Is there a current Mental Health Treatment Plan in place? *(If yes, please attach to this referral)* ☐ Y ☐ N

Does the consumer have NDIS funding in place? ☐ Y ☐ N

Would the person prefer to access a dedicated organisation that supports people who identify as:

☐ Aboriginal and Torres Strait Islander ☐ Culturally and Linguistically Diverse ☐ LGBTIQAP+

This activity is supported by funding from Gold Coast PHN through the Australian Government's PHN Program.

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Emergency Contact Name: Phone Number:	Relationship to person: Parent/Guardian/Carer

Risk of Harm	
Risk of Harm	Potential for harm to self or others: Is the person currently self-harming? ☐ Y* ☐ N Is the person at increased risk of suicide? ☐ Y* ☐ N Is there a risk of harm to others? ☐ Y* ☐ N *If yes please provide details of **action taken** and attach risk assessment: ****Please note this is not a crisis service. If assessed at very high risk of harm, please contact Emergency Services on 000 or Acute Care Team on 1300 642 255.**

Referral Notes	
Mental health diagnosis	
Symptom severity and level of distress	
Medications	
Treatment Goals and Hopes of the Patient	
Please provide any additional information and/or identified needs to help inform the assessment and conversation with consumer	
Please list any other referrals made or existing services being accessed:	

Forward completed referral via Medical Objects to: ***Head to Health Gold Coast Referrals*** or Fax: 07 3186 4099

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