COVID Recovery Service (Border Communities) Referral

Confirmation of eligibility criteria
(must confirm all three ☑)
☐ Resides in Queensland in the Border Community region along the QLD/NSW Border
☐ Benefit from short-term intervention
☐ COVID related Mental Health/Wellbeing decline

Referral Type (☑ **at least one referral type**)
☐ Small business owner, their family or staff
☐ Individual or family continuing to experience significant impact on mental health and wellbeing as a result of COVID

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 Queensland Health and PHN-commissioned services when indicated
☐ the support person identified on this referral being contacted by the service provider.
☐ de-identified information on this referral form being shared with Queensland 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:_____
☐Accident / injury
☐Grief / loss
☐Physical Disability
☐Intellectual disability
☐Physical Health decline
☐Mental Health decline
☐Loneliness/isolation
☐ Carer, unpaid
☐Legal / corrections issues
☐Alcohol or drug related problems
☐Gambling / other addiction
☐Discrimination
☐Trauma/abuse
☐Bullying and/or harassment
☐Divorce or separation
☐Other, specify: _____

Reason for referral/presenting concerns:
_____
_____
_____
_____
_____
_____

Required service/s:
☐ Psychological Therapies/Counselling
☐Psychosocial Support

At the completion of this referral please fax to (07) 3539 6426 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 Queensland Health.