|  |  |  |
| --- | --- | --- |
| DOB |    | PID Number |
| Gender |   |   |
| Title |   | Surname |   |
| Given Names |   |
| Address |   |
|  | *(Type or affix sticker)* |

|  |
| --- |
| **Referrer\*** |
| **Doctors Name:** |       |
| **Medical Centre:** |       |
| **Contact phone number:** |       | **Fax number:** |       |
| **Email:** |       |
|  |
| **Client Details** |
| **Surname:** |       | **Client Address:**      |
| **First name:** |       |
| **Date of birth\*:***Must be over 18 years* |       | *Is this the client’s permanent address?*[ ]  Yes [ ]  No |
| **Client Phone Number:** |       |
| **Health Care Card:** | [x]  Yes [x]  No | **Health Care Card Number:**       |
| **Medicare Care number:** |       |
| **Next of Kin name and contact number:**       |
| **Identify as:** [ ]  Aboriginal [ ]  Torres Strait Islander [ ]  Both [ ]  Neither |
| **Gender:** [x]  Male [ ]  Female [ ]  Non-Binary [ ]  Other |
| **Ethnicity:**       |
| **Interpreter required?** [x]  Yes [ ]  No | **Language:**       | **Hearing impaired?** [ ]  Yes [ ]  No |
| **Patient consents to referral?** [ ]  Yes [ ]  No |

|  |
| --- |
| **MUST HAVE A CHRONIC DISEASE AND MENTAL HEALTH AND/OR AOD COMPLEXITY TO BE ELIGIBLE FOR THE SERVICE\*** |
| **Chronic Diseases**  |
| **Diabetes, Cardiac Condition, Respiratory, etc (can attach a Health Summary)**Comments:       |
|  |
| **Mental Health History\*** [ ]  **N/A**  |
| **Mental illness diagnosis:**       |
| **Current mental health therapies:**       |
| **Previous mental health therapies:**       |

|  |
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| **Alcohol and Other Drugs History\***  |
| **Client is currently engaged in risky alcohol use** [x]  Yes [ ]  No |
| **Client is currently engaged in risky drug use**  [x]  Yes [ ]  No |
| **Client has previously tried to reduce harm by:** Comments:       |
| **What support does the client require from this service?** |
| Comments:       |
| **GP Management Plan**Does the client have a GPMP? [ ]  Yes [ ]  NoAttached? [ ]  Yes [ ]  No | **Mental Health Care Plan**Does the client have a MHCP? [ ]  Yes [ ]  No [ ]  N/AAttached? [ ]  Yes [ ]  No |
| **Risk Factors:** [ ]  Smoking  [ ]  Unstable Housing [ ]  At risk of family violence  [ ]  Financial disadvantage [ ]  History of incarceration |
| **Safety concerns: \***Are there any concerns in relation to this client’s behaviour that may compromise staff safety?[ ]  Yes [ ]  NoIf Yes, please describe:       |
| Known Risks: Previous suicidal ideation [ ]  Yes [ ]  No [ ]  unknown Risk of harm to self [ ]  Yes [ ]  No [ ]  unknown Risk of harm to others [ ]  Yes [ ]  No [ ]  unknown Risk of harm from others [ ]  Yes [ ]  No [ ]  unknown Other comments: |
| **Current Medications: (can attach a Health Summary)**      |

**Please send completed referrals to:**

**Fax:** 1300 601 788 **Email:** screferrals@silverchain.org.au