|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 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:** | Yes  No | | **Health Care Card Number:** | | |
| **Medicare Care number:** |  | | | | |
| **Next of Kin name and contact number:** | | | | | |
| **Identify as:**  Aboriginal  Torres Strait Islander  Both  Neither | | | | | |
| **Gender:**  Male  Female  Non-Binary  Other | | | | | |
| **Ethnicity:** | | | | | |
| **Interpreter required?**  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:** |

|  |  |
| --- | --- |
| **Alcohol and Other Drugs History\*** | |
| **Client is currently engaged in risky alcohol use**  Yes  No | |
| **Client is currently engaged in risky drug use**   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  No  Attached?  Yes  No | **Mental Health Care Plan**  Does the client have a MHCP?  Yes  No  N/A  Attached?  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  No  If 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](mailto:screferrals@silverchain.org.au)