BHCC 4

BRIDGES
Health & Community Care

Client Referral Form
PRIVATE & CONFIDENTIAL

CONSENT

All Bridges services are voluntary
Please confirm that you have client consent for this referral by Xing the appropriate box below

Written Consent ☐
Verbal Consent ☐

Personal Details

Name	Date of Birth
Address	
Does the person identify as Indigenous ☐ No ☐ Yes	Gender ☒ Male ☐ Female
Country of Birth Australia	Preferred Language English / Translator Required ☒ No ☐ Yes
Please provide details of how the client wishes to be contacted by Bridges to arrange an appointment – multiple boxes can be X'ed	
☐ Phone No. 1	☐ Phone No. 2
Most convenient time to call	Can we leave a message on your phone(s)? ☐ Yes ☐ No
☐ Email	☐ Letter to home address

Services Required – you may X more than one box

☐ **Bridges Psychology Practice** ☐ **Drug & Alcohol Treatment Service** ☐ **Youth Mental Health**

☐ **Mental Illness & Complex Needs (NEW PROGRAM - PIR)** ☐ **Fresh Start – Quit Smoking Program**

☐ **Mental Health Rehabilitation & Recovery Services** **Centre-based** ☐ **Outreach (MHOPs)** ☐

Reason for Referral - Other Information Relevant to Treatment (e.g. Diagnoses, Substances Used, Presenting Issues, Risks, etc). *Please attach any supporting documentation*

Presenting Mental Health Issue Eg, Diagnosis, issue – anxiety, depression etc	
Drug &/or Alcohol Issue Eg alcohol, cannabis	
Other Health issues or Psychosocial Factors Eg, medical factors, other diagnosis, homelessness, stress, social situation	
Risk Factors Eg Harm to self or others, suicide risk, vulnerability,	

Is there a GP Mental Health Care Plan- Item 2710	☒ No	☐ Yes GP:	Medicare number: Exp:
Is this referral part of an EPC or ATSI Health Check?	☒ No	☐ Yes	
Is referral part of a JSA Employment Pathway Plan (EPP)?	☒ No	☐ Yes	

Person Making Referral

Name	Date of Referral
Organisation	Provider Reg. No (if GP)
Fax Phone	Email
Signature	

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