Mental Health Services DIRECT REFERRAL FORM

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 Wesley Mission Queensland Intake team to deliver intake services. This information will be used to assess initial eligibility for Mental Health Programs and WMQ will contact the person for intake if eligible.

Please indicate the information in this form has been discussed with, and provided to the client, and the client is aware deidentified data is shared with GCPHN, BSPHN,DoH and Australian Department of Health and Aged Care for research and evaluation purposes to improve quality and access to care ☐Y ☐N

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

Consent to sharing details below with additional services such as Head to Health ☐Y ☐N

REFERRER INFORMATION

Referral Date:		Referrer Profession:	
Referrer Name:		Referrer Phone:	
Organisation:		Referrer Fax (or email):	

ELIGIBILITY

Please tick any that apply below:

- ☐ Benefit from Short Term Intervention (required)
- ☐ Mild to Moderate Mental Health needs
- ☐ Identifies with the LGBTIQAP+ community and/or are questioning sexuality or gender identity, requiring culturally specific support.
- ☐ Requiring Structured Psychological Interventions (Clinical Supports)
- ☐ Requiring Psychosocial Supports
- ☐ Current suicidal ideation or at risk of suicide

CLIENT PERSONAL INFORMATION

Legal Name: *First and Surname		Preferred Name:	
Date of Birth:		Gender:	
Country of Birth:		Pronouns:	
Main Language Spoken:	Interpreter required ☐Yes ☐No	Health Care Card:	☐Yes ☐No ☐Unknown
Ethnicity:	☐Aboriginal ☐Torres Strait Islander ☐South Sea Islander ☐Australian ☐Other:_____		
Address:		Postcode:	

CLIENT CONTACT INFORMATION

Phone:		Is it safe to call/text?	☐Yes ☐No ☐Unknown
Support Person / Relationship:		Support Contact:	

ADDITIONAL INFORMATION

Reason for Referral:	
Barriers to Accessing Service:	
Risk of Harm to Self or Others:	*Please not this is not a crisis service - If person is at high risk of harm, please contact emergency services on 000 or Acute Care Team on 1300 642 255 * Details: ☐ The client has had thoughts of self-harm or suicide within the past four weeks. * Please tick if relevant
Other Services Being Accessed, Relevant Diagnoses and Additional Notes:	

Please attach any additional information or documents if required and return to the Intake team at: MentalHealthIntake@wmq.org.au or send as a fax to 07 3539 6444 or Medical Objects: MS42140001L

Click to Clear

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