wesley mission QUEENSLAND

Psychological Therapies Program Review Form

PLEASE NOTE

**This form is for review purposes only. If this is the first time you are referring your patient please complete a new referral*

**This form can be used if a client requires a change in program, support intensity or additional support needs*

**Any period greater than 3 months between blocks will require a new referral*

Review Type

☐ Additional General block of 6 sessions

☐ Additional Suicide Prevention/Self Harm block

☐ Step up – To Suicide Prevention

☐ Step Down – From Suicide Prevention To:

(☑ **at least one referral type**)
- ☐ Perinatal depression/anxiety (Child<2)
- ☐ Child< 12
- ☐ LGBTIQAP+
- ☐ Homelessness (or at-risk of)
- ☐ Aboriginal and Torres Strait Islander
- ☐ Domestic and family violence
- ☐ Rural and remote

Date of review:___________________________

Name of GP:______________________________

Practice name: ___________________________

Phone:___________________________________

Fax: _____________________________________

Primary reason for additional referral

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Client Information

Client full name:____________________________ **DOB:**________________

Pronouns: ☐He/Him/His ☐ She/Her/Hers ☐They/Them/Theirs

Gender: ☐Male ☐ Female ☐Transgender Female (Male-To-Female) ☐Transgender Male (Female-To-Male) ☐Non-Binary ☐Other: ___________

Street Address: ____

Suburb: ______________________________**Postcode:**___________________

Home Phone: _________________ **Mobile:**____________________________

OK to leave message ☐ Yes ☐ No

Health Care Card: ☐ Yes - expiry: _______________ ☐ No

Has the client has had thoughts about hurting or killing themselves in the past 4 weeks but is not at immediate risk? *(If Crisis support is required please contact Acute Care Team or Ambulance)* ☐Yes ☐No ☐Unknown

Any changes in contributing factors (☑ all that apply)

☐Chronic disease:________________
☐Serious accident / injury
☐Grief / loss
☐Physical Disability
☐Intellectual disability
☐Divorce or separation
☐Sexual assault/abuse
☐Unable to secure employment
☐Legal / corrections issues
☐Alcohol or drug related problems
☐Gambling problem / other addiction
☐Discrimination
☐Trauma
☐Bullying and/or harassment
☐Child safety interactions
☐Other, specify: ________________

At the completion of this review please fax to (07) 3539-6445 or alternatively via Medical Objects secure messaging to address QW4106000LX Wesley Mission QLD Psychological Therapies.

If you have any questions please contact a member of the Psychological Therapies team on (07) 3151-3840

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