# **Country & Outback Health**

# **Community Referral – Primary Mental Health**

**For people residing in:**

* **Coober Pedy, Wudinna and Streaky Bay communities**
* **Residing in Barunga Village & Moonta Health and Aged Care facilities.**

***Please email to admin@cobh.org.au, fax to 8312 2506, phone 8643 5600 or***

***post to Country & Outback Health, Attention: Intake,* *12 Chapel Street, Port Augusta SA 5700***

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Full name on Medicare card** |  | | | | **Date of Birth** | |  | | | |
| **Preferred name(s)** |  | | | | **Gender** | |  | | | |
| **Mobile** |  | | | | **Other Phone** | |  | | | |
| **Are there any restrictions regarding how or when we contact you?** | | | | | | | | | | |
| **Residential Address** |  | | | | | | | | | |
| **Postal Address** |  | | | | | | | | | |
| **Email:** |  | | |  | | | |  | | |
| **Identify as Aboriginal or Torres Strait Islander?** | No  Aboriginal  Torres Strait Islander  Both | | | | | | | | | |
| **Existing Mental Health Treatment Plan** | | | | | Yes  No | | | | | |
| **GP Practice Name** |  | | | | | | | | | |
| **Name of GP** |  | | | | | | | | | |
| **Address** |  | | | | | | | | | |
| **Phone Number** |  | | | | **Date of Referral** | |  | | | |
| Consent given for a referral to be sent to Country & Outback Health | | | | | Yes  No | | | | | |
| **Under 16** **only** - Has parent/guardian consented to the referral? | | | | | Yes  No | | | | | |
| Name of Emergency contact person: Phone:  Consent to share information: Yes  No | | | | | | | | | | |
|  |  | |  |  | | | | | | |
| **Referrer Name** |  | | | **Organisation** | |  | | | | |
| **Phone** |  | | | **Email** | |  | | | | |
| **Address** |  | | | | | | | | | |
| **Reason for referral** | | | | | | | | | | |
| **How long has this been a concern or a problem:** | | | | | | | | | | |
| **Current Stressors** | | | | | | | | | | |
| Suicidal Ideation | | Yes  No | | \*\*Suicidal Intent / Plan | | | | | Yes  No | |
| Previous Attempt | | Yes  No | | Access to Methods | | | | | Yes  No | |
| History of Self Harm | | Yes  No | | Risk to Others | | | | | Yes  No | |
| Lives Alone | | Yes  No | | Drug or Alcohol use | | | | | Yes  No | |
| **Please list agencies & other supports available i.e. family or friends** | | | | | | | | | | |
| Client Signature …………………………………………….  Parent/Guardian Signature (If client under 16) …………………………………………….  Parent/Guardian Name (If client under 16) ……………………………………………. | | | | | | | | | | Date: \_\_\_ / \_\_ /\_\_\_\_ |