# **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***

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| --- | --- | --- | --- |
| **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: \_\_\_ / \_\_ /\_\_\_\_ |