TOWNSVILLE

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NORTHERN AUSTRALIA
PRIMARY HEALTH LTD
A healthier future for all Australians

OFFICE HOURS Monday to Friday 8.30am – 4.30pm

Referral Form
Mental Health 12 - 25 Years

If you consider this referral a high priority please call our office after faxing the referral

Eligibility

This person is between 12 – 25 years old Yes ☐ No ☐

This person has a current Mental Health Treatment Plan Yes ☐ No ☐

This person has attended less than 12 Stepped Care or 10 Better Access sessions in the current calendar year Yes ☐ No ☐

Persons Details

First Name | Surname
DOB | Gender
Address | Postcode
Phone (work) | Phone (home) | Mobile
Indigenous Status | Interpreter Required Yes ☐ No ☐
Medicare Card # | Ref # | Expiry | Health Care Card # | Expiry
Applicable Private Health Insurance? Yes ☐ No ☐

Contacts (Complete relevant field/s)

Can we contact these people if we are unable to contact the referred person to schedule an appointment Yes ☐ No ☐

Next of Kin/ Emergency Contact:

Name | Phone
Address | Postcode
Relationship to person:

Carer Details: (if applicable)

Name | Phone

Referrer Details (if applicable)

Name
Organisation
Address | Postcode
Fax | Provider Number

Referral Information

Reason for Referral
Diagnosis
Allergies
Current Medications (Please attach medications summary)

Relevant medical history/conditions (Please attach health summary)

Reason for Referral

☐ Counselling Services

☐ Drug and Alcohol Intervention

☐ Social Recovery Groups

☐ Health Review/GP Services

K10 or EPNDS Score:

Known Risks

Are there any known risks to self/others/staff?: Yes ☐ No ☐

If yes please provide further information

Consent to referral:
I have discussed this referral with the person and/or their guardian and am satisfied that the person and/or their guardian understands a
able to provide informed consent to this referral

Referrer's signature: ____

Referral Date:

If relevant please attach GP Mental Health Treatment Plan (MHTP), Medication Summary and Health Summary

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