MENTAL HEALTH THERAPY
Referral Form

Must be completed by Health Practitioner or GP

To Be Eligible Client Must Meet All Three Criteria Below

1. *Must be financially disadvantaged (e.g. Health Care Card or unemployed) or not have access to alternative care*
2. *Experiencing a mild to moderate mental health illness*
3. *Currently not in crisis or in need of urgent assistance*

REFERRAL WILL NOT BE ACCEPTED IF ALL INFORMATION IS NOT COMPLETED

CLIENT DETAILS:

Surname: ______________ First Name: ______________ DOB: __________

Phone: ______________ Email: ______________

Address: ______________

Postal Address *(if different from above)*: ______________

Parent/Guardian Name *(if under 16)*: ______________

Phone: ______________ Signature: ______________

Next of Kin: ______________ Phone: ______________

Pension Card/HCC No: ______________ NDIS Participant: ☐ Yes ☐ No

Court Order: ☐ Yes ☐ No

IMPORTANT: Please complete the following questions

Do you identify as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither

Gender: ☐ Male ☐ Female ☐ X (Indeterminate/Intersex/Unspecified)

Type of employment: ☐ Unemployed ☐ Full-time ☐ Part-time ☐ Not in Labour Force

Source of Income: Mental Health Care Plan: ☐ Yes ☐ No

Homelessness: ☐ No ☐ Short-term Emergency ☐ Sleeping Rough

Marital Status: ☐ Widowed ☐ Married/Defacto ☐ Never Married ☐ Divorced/Separated

Country of Birth: Perinatal: ☐ Yes ☐ No

Main Language Spoken at Home: ☐ English Only ☐ Other *(please state)*:

How well does this person speak English? ☐ Very Well ☐ Well ☐ Not Well ☐ Not at All

REFERRER DETAILS: (If not GP, please also fill in GP Details below)

Name: ______________ Phone: __________ Fax: __________

Organisation: ______________ Position: ______________

Address: ______________

Referrer Email: ______________

Other agencies involved: ______________

GP DETAILS:

GP Name: ______________ Phone: __________ Fax: __________

Practice: ______________

Address: ______________

Email: ______________

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Amity Health Mental Health Portal is funded by Department of Health through **WAPHA** (Western Australia Primary Health Alliance)

REASON FOR REFERRAL:			
Risk of harm to self in last 6 months:	☐ Suicide	☐ Self-harm	
Current Alcohol Use: ☐ Yes ☐ No		Other drugs: ☐ Yes ☐ No	
Medications *(please list)*:			
Previous Mental Health history:			
Reason for this referral:			

CONSENT:

☐ I have discussed this referral with the client and the client consents to being referred to Amity Health Mental Health Portal

Referrer Signature: ______________________________ Date: ______________

PLEASE PROVIDE YOUR CLIENT A COPY OF THIS REFERRAL

Please return this completed form and any other relevant documentation to Amity Health via one of the following methods:

Fax: 08 9842 2798 or

Email: query@amityhealth.com.au

For enquiries please contact the Amity Health Mental Health team on 08 9842 2797

INFORMATION FOR CLIENT:

Amity Health will contact you via phone. Please contact Amity Health on 08 9842 2797 to book an appointment if you have not heard from us in 7 days.

This is a funded program through WA Primary Health Alliance, there is no cost to use this service.

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