

CULTURALLY DIVERSE PSYCHOLOGICAL SERVICE GENERAL REFERRAL FORM

(If a general practitioner (GP)/Psychiatrist/Paediatrician please use GP Referral Form)

Eligibility: The service is for clients from a CALD background, 12+ years old with mild to moderate psychological presentations with barriers to accessing MBS psychological services. Clients will receive short-term clinical intervention (up to 10 sessions) culturally appropriate and evidence-based psychological support. Interpreters are used as needed. Australian Citizens, Permanent Residents and those holding a valid Medicare Card. The service is free and is Perth metro wide.

The client will still need a General Practitioner (GP) referral to receive counselling with the service (please support the client to consult a GP for a referral if able).

Exclusions: Clients who are at high risk, or with complex and severe mental health illness, for example: psychotic disorders, personality disorders, bipolar disorder, complex PTSD, learning disorders, autism spectrum disorders, attention related disorders, major drug and alcohol issues. NDIS participants. This is not a crisis service.

CLIENT DETAILS

SURNAME				FIRST NAME			
GENDER	MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>	OTHER <input type="checkbox"/>	DATE OF BIRTH		AGE	
ADDRESS						POST CODE	
TELEPHONE	MOBILE:			WORK:		HOME:	
EMAIL ADDRESS				CLIENT CONSENT TO REFERRAL	YES <input type="checkbox"/> NO <input type="checkbox"/>		
BEST TIME TO CONTACT							
MEDICARE CARD	YES <input type="checkbox"/> NO <input type="checkbox"/>			MEDICARE NUMBER			
COUNTRY OF ORIGIN				YEAR OF ARRIVAL IN AUSTRALIA			
ETNICITY				RELIGION / SPIRITUALITY			
LANGUAGES SPOKEN			PREFERRED LANGUAGE			INTERPRETER NEEDED: YES <input type="checkbox"/> NO <input type="checkbox"/>	
RELATIONSHIP STATUS				OCCUPATION			
IF CHILD, NAME OF CARER / LEGAL GUARDIAN				CARER / LEGAL GUARDIAN CONSENT TO REFERRAL		YES <input type="checkbox"/> NO <input type="checkbox"/>	
CLIENT CONTACT NUMBER DIFFERENT FROM THE CARER/ LEGAL GUARDIAN	YES <input type="checkbox"/> NO <input type="checkbox"/>			CARER / LEGAL GUARDIAN CONTACT NUMBER			

CULTURALLY DIVERSE PSYCHOLOGICAL SERVICE GENERAL REFERRAL FORM

(If a general practitioner (GP)/Psychiatrist/Paediatrician please use GP Referral Form)

REFERRAL DETAILS

REASONS FOR REFERRAL

OTHER RELEVANT BACKGROUND INFORMATION

SUICIDAL IDEATION	YES <input type="checkbox"/>	NO <input type="checkbox"/>	LEVEL High <input type="checkbox"/>	Low <input type="checkbox"/>
--------------------------	------------------------------	-----------------------------	-------------------------------------	------------------------------

SELF HARMING BEHAVIOURS	YES <input type="checkbox"/>	NO <input type="checkbox"/>	LEVEL High <input type="checkbox"/>	Low <input type="checkbox"/>
--------------------------------	------------------------------	-----------------------------	-------------------------------------	------------------------------

CLIENT A RISK TO CHILDREN / OTHERS	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If yes, details:
---	------------------------------	-----------------------------	------------------

LEGAL ISSUES / COURT ORDERS	YES <input type="checkbox"/>	NO <input type="checkbox"/>
------------------------------------	------------------------------	-----------------------------

IF CHILD PROTECTION CASE	YES <input type="checkbox"/>	NO <input type="checkbox"/>	UNKNOWN <input type="checkbox"/>
	OPEN <input type="checkbox"/>	CLOSED <input type="checkbox"/>	UNKNOWN <input type="checkbox"/>

OTHER SERVICES SUPPORTING THE CLIENT	
---	--

REFERRER DETAILS

NAME	
ROLE	
AGENCY / SERVICE	
ADDRESS	
TELEPHONE	
EMAIL ADDRESS	
REFERRAL SUBMITTED ON	(DD/MM/YYYY)

A GP Progress Report will be generated after 6 sessions and a GP Final Report after 10 sessions.

Please email completed Referral Form to cdps.referrals@lwb.org.au



LIFE WITHOUT BARRIERS