**CMRH Mental Health Triage and Referral form**

 ***for SoberMinds Mental Healthcare Services***

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|  **This form is for:** * Self-referral
* Referrals from a family member, carer, or friend
* Referrals from community organisations
* Referrals from the health professional

**CMRH provides onsite counselling and referrals to culturally safe, appropriate, and specific mental health services** |
| **Referral Details** |  |  |  |
| Referral Name: |  | Date of referral: |  |
| Referrer organisation (N/A for self or family referral): |  | Referrer profession OR relationship to a client (e.g., social worker, self, carer etc.) |  |
| Referrer address: |  | Alternative phone (if applicable): |  |
| Referrer email address: |  |  |  |
| **Client Information** |
| Has the person consented to a referral for an initial assessment and further treatment?

|  |  |  |
| --- | --- | --- |
|  | No |  |

 Yes If ‘No’, do not proceed with the referral. |
| Client name:  |  |
| Date of birth: |  | Gender:  |  |
| Country of birth: |  | Preferred language  | Interpreter  |
| Address:  |  |  |  |
|  | Suburb:  |  | Postcode:  |  |
| Client phone:  |  | Email:  |  |
| Marital status:  |  |
| Demographic Information  |
| *Tick if applicable, leave blank if unknown* |
| Rural and Remote resident |  | Culturally and Linguistically Diverse background |  |
| Aboriginal and Torres Strait Islander |  | LGBTIQ community`s member |  |
| Existing mental health issues |  | Concession cardholder |  |
| Affected by Domestic Violence |  | Homeless (e.g., sleeping rough or couch surfing |  |
| NDIS participant |  | Dept. Veterans Affairs card holder |  |
| Private health insurance |  | Currently employed |  |

Email this form to *info@cmrh.org.au*