Referral Form

Cnr Sittella Street and
Teal Street, Inala Q 4077
(07) 3372 1711
Oasis@ich.org.au
www.ich.org.au

Medicare Accredited Mental Health Social Worker *Mental Health Care Plan*

Referred By (Name & Contact)

Date Of Referral:

GP Name

GP Contact Detail

Medicare No

Client's Details & Information

Client's Full Name

Date Of Birth:

Address

Phone Number

Email Address

Country of Birth

Citizenship or Visa Status

Language Spoken at Home

Does the client require an interpreter? ☐ Yes ☐ No

Client Occupation and Financial Status

Client Housing Details

Emergency Contact

Name

Relationship

Contact

Any primary diagnosis?

☐ Yes ☐ No

If Yes, please specify

Any medications?

☐ Yes ☐ No

If Yes, please specify

Presenting issues (mental & physical health needs)?

☐ Yes ☐ No

If Yes, please specify

Any domestic & family violence issues?

☐ Yes ☐ No

If Yes, please specify

Any drugs or alcohol abuse?

☐ Yes ☐ No

If Yes, please specify

Any safety risks or relevant criminal history/issues?

☐ Yes ☐ No

If Yes, please specify

Any child safety or youth justice involvement?

☐ Yes ☐ No

If Yes, please specify

Please include details about reason for referral and needs identified

Client Consent

I, ______________________ *(client name)* consent to this referral to proceed and agree to personal information about my health to be shared between the referrer and the Social Worker at The Oasis Centre for the purpose of further mental health assessment and intervention.

Signature

Date