

Perinatal Wellbeing

Community Referral Form



The Community Referral Form can only be completed by Child and Maternal Health Nurses, Midwives and Obstetricians. It is provisional and provides access to a limited number of sessions with a Mental Health Clinician. To access the full number of sessions, a Mental Health Treatment Plan must be completed by the client's GP and faxed to the Central Referral Unit (1300 580 249).

Client details

Name:		Date of Referral:	
DOB:		Gender:	
Address:		Phone:	
Does the client identify as Aboriginal or Torres Strait Islander?			<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Neither
Does the client give consent to the referral?			<input type="checkbox"/> Yes / No <input type="checkbox"/>

Referrer details

Name:		Position:	
Phone:		Fax:	
Organisation:			
Address:			
Signature:		Date:	
Reasons for referral:			
Any other services involvement?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure		

Does the client have a GP?	<input type="checkbox"/> Yes / No <input type="checkbox"/>		
Name:		Phone:	
Practice:			
Address:			

Risk Assessment (must complete)

Has current suicidal thoughts	<input type="checkbox"/> Yes (If yes, please contact Sonder.)	<input type="checkbox"/> No
Has a current plan to end their life	<input type="checkbox"/> Yes (If yes, please contact Sonder.)	<input type="checkbox"/> No
Has attempted suicide in the last 6 months	<input type="checkbox"/> Yes (If yes, please contact Sonder.)	<input type="checkbox"/> No
Is at risk of harming others (due to violence/ aggression)	<input type="checkbox"/> Yes (If yes, please contact Sonder.)	<input type="checkbox"/> No
Other comments:		

Please fax completed referral form to the Central Referral Unit on 1300 580 249.