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?			◯ Aboriginal ◯ Torres Strait Islander ◯ Both ◯ Neither
Does the client give consent to the referral?			◯ Yes / No ◯

Referrer details

Name:		Position:	
Phone:		Fax:	
Organisation:			
Address:			
Signature:		Date:	
Reasons for referral: **(please include age of the child/client's pregnancy status)**			
Any other services involvement?	◯ Yes ◯ No ◯ Unsure		

Does the client have a GP?	◯ Yes / No ◯		
Name:		Phone:	
Practice:			
Address:			

Risk Assessment (must complete)

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

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