Suicide Prevention Service
Referral Form

Sonder
Better Care Better Health

Please fax completed form to Sonder on (08) 8252 9433

Date of contact with referrer:		72-hour contact date with client:	
Clinician:			

Client details

Name:			
D.O.B:		Gender:	
Address:		Phone:	
		Mobile:	
Does the client identify as Aboriginal or Torres Strait Islander?:		☐ Aboriginal ☐ Torres St. Islander	☐ Both ☐ None
Emergency contact:		Phone:	
Any other support services/persons involved in the client's care?			

Referrer Details

Name:		Phone No:	
Organisation:		Fax:	
Address:			

Referral Information

Has the client taken action to harm themselves or others? (if yes, provide details below)		☐ Yes / No ☐
Risk Factors (Acute Situation)		
Suicidal thoughts	☐ **Yes / No** ☐	if yes, provide details below
Access to means	☐ **Yes / No** ☐	if yes, provide details below
Previous attempt/s	☐ **Yes / No** ☐	if yes, provide details below

Imminent Danger – Implement emergency procedures

Plans/intent	☐ **Yes / No** ☐	if yes, provide details below
Psychiatric care/illness	☐ **Yes / No** ☐	if yes, provide details below

GP Details

Name:		Phone:	
Organisation:		Fax:	
Address:			

--- Office Use Only ---

Referral Outcome

☐ **Referral accepted**	☐ **High risk/crisis – refer to MH Triage**
☐ **Not suitable – referred internal**	☐ **Not suitable – referred external**
Details of referred service/s:	
General information regarding client's situation:	
Confirmed contact with client date:	
Appointment date and time:	