COVID & Your Wellbeing
Self Referral Form

Sonder
Better Care Better Health

Please fax completed referral form to Sonder on **(08) 8252 9433** or email to info@sonder.net.au

Date of referral:	

About You

Name:			
D.O.B.:		**Gender:**	
Residential address:			
Mobile number:			
Email address: (if applicable)			

Referrer details

Name:			
Phone number:		**Fax: (if applicable)**	
Organisation:			
Email address:			

Referral information

Reason/s for referral:		
Are you (tick if applicable)	☐ Aboriginal or Torres Strait Islander ☐ CALD or migrant background	
Risk assessment	Has current suicidal thoughts?	☐ **Yes (please contact Sonder)** ☐ **No**
	Has a current plan to end their life?	☐ **Yes (please contact Sonder)** ☐ **No**
	Has attempted suicide in the last 6 months?	☐ **Yes (please contact Sonder)** ☐ **No**
	Is at risk of harming others (due to aggression / violence?	☐ **Yes (please contact Sonder)** ☐ **No**
Does the client have a GP?	☐ **Yes** / **No** ☐	
GP's Name:		**Practice:**
Does the client have a Mental Health Treatment Plan? (please note: a MHTP is not required for access)	☐ **Yes** / **No** ☐	

I _____ agree to be referred to Sonder.
(print name)

Client's signature: _____ **Date:** _____

Referrer's signature: _____ **Date:** _____