

Perinatal Wellbeing

Community Referral Form



This 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. This community referral form is only valid for Sonder services in the metro Adelaide region.

Client details

Date of referral:			
Name:			
DOB:		Gender:	
Address:		Home number:	
		Mobile number:	
Parent/Caregiver:		Relationship to client:	
Is the client a member of any of the following priority groups? (please tick below)			
<input type="checkbox"/> Aboriginal or Torres Strait Islander <input type="checkbox"/> CALD or Migrant background <input type="checkbox"/> Suspended/excluded from school <input type="checkbox"/> Involved with the Juvenile Justice System <input type="checkbox"/> Known/involved with DCP or at risk of DCP involvement <input type="checkbox"/> LGBTQIA +			

Referrer details

Name:			
Phone:		Fax:	
Organisation:			
Address:			

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"/>

Risk Assessment (must complete)

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

Please fax completed referral form to Sonder on 08 8252 9433.

Consent

I, _____, agree to be referred to Sonder.

Client signature: _____ Date: _____

Referrer signature: _____ Date: _____

Client consent to release information (if applicable)

I, _____ (Client's full name) give my permission for
_____ (Referrer's full name) to provide/receive written
and verbal information to/from Sonder for the purpose of facilitating this referral.

Client signature: _____ Date: _____

Referrer signature: _____ Date: _____

For clients under 16 years:

Parent/guardian name: _____ Parent/guardian signature: _____