

Psychological Therapies Program Referral

Please note the psychological therapies program offers intake assessment, service navigation and short-term psychological intervention for people experiencing mild-to-moderate mental illness and living in the Toowoomba, Lockyer Valley and Somerset LGAs.

Client Information:

Full Name:	Mr/Mrs/Miss/Ms/Other_____
Preferred Name:	Date of Birth:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other_____	Phone no:
Preferred pronouns:	
Address:	
Email:	
Main language spoken at home:	Interpreter required: <input type="checkbox"/> Yes <input type="checkbox"/> No
Cultural background: <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Neither <input type="checkbox"/> Prefer not to say	
NDIS Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure If yes are psychosocial supports included in their plan <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	
Is the client aware of and consenting to this referral: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure If under 15 years, the parent/carer of the young person has provided consent for this referral: <div style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure</div> If no or unsure, please provide details: _____	

Emergency Contact Information:

Full Name:	Mr/Mrs/Miss/Ms/Other_____
Relationship with client:	
Phone Number:	Email:



Family Services Australia

THIS SERVICE IS SUPPORTD BY DARLING DOWNS AND WEST MORETON PHN

At the completion of this referral please email to triage@familyservices.org.au
If you have any questions, please contact Family Services Australia at 1800 FSA 000 (1800 372 000) [Option 2]

Referrer Details:

Name:	Profession:
Provide No:	Practice Name:
Phone Number:	Fax (if applicable):
Email:	

Clinical information:

Formal diagnosis of mental health condition: _____
In the past 4 weeks, has the client had thoughts about hurting or killing themselves: <input type="checkbox"/> Yes <input type="checkbox"/> No
Client has been hospitalised for Mental Health concern in last 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No
Duration of mental health intervention required: <input type="checkbox"/> Short term <input type="checkbox"/> long term <input type="checkbox"/> Crisis
GP mental health treatment plan developed: <input type="checkbox"/> Yes <input type="checkbox"/> In process of development
<u>Reason for referral/presenting concerns:</u>

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Outcome tool used: (one option)

- K10, Score _____ K5, Score: _____
- SDQ (Parent 4-10 years) score: _____ SDQ (Parent 11-17 years) score: _____

Are there any known risk concerns? E.g., self-harm, suicidality, risk to others, etc. If yes, please provide details below.

Other contributing factors/relevant information, e.g., co-existing medical conditions, abuse, grief/loss, substance use, social stressors:

Please send this completed referral form, along with any additional relevant information via email to triage@familyservices.org.au. If you have any questions, please contact us on 1800 372 000 (Option 2).



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