CP013 - REFERRAL TO CHMR OUTREACH SERVICE

Please send completed referral Form to chmreception@cyrenianhouse.com or fax to (08)9192 8410

REFERRER DETAILS			
Referrer's name		**Position:**	
Organisation:		**Contact number:**	
Email:			
Date of referral:		**Is the person being referred aware of this referral?**	Yes ❒ No ❒

CONSUMER DETAILS					
Given Name:		**Family Name:**			
Alias:		**Date of Birth:**			
Address:					
Phone (Home):		**Mobile:**		**Work:**	
Permission to leave a voice or text message:	Yes ❒ No ❒				
Next of Kin:		**Contact Number**:			
Name of GP:					

Previous contact history:

Milliya Rumurra: Yes ❒ No ❒ **KMHDS:** Yes ❒ No ❒ **DCPFS:** Yes ❒ No ❒ **DoCS:** Yes ❒ No ❒

Other:	
Reason for Referral:	
Report Required:	Yes ❒ No ❒
Substance Use history:	
Mental Health History:	
Medication(s):	
Physical Health:	

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History of Violence / Offending history:	
Legal Status:	(Current/pending legal matters :)
Other issues of concern:	

Currently pregnant:	Yes ❒ No ❒	
Positive for BBV:	Yes ❒ No ❒	
History unsafe injecting practice:	Yes ❒ No ❒	(Please attach any further information/details that may be relevant to this referral)
Current suicidal ideation:	Yes ❒ No ❒	
Deliberate self-harm/behaviour:	Yes ❒ No ❒	
Currently lives alone:	Yes ❒ No ❒	
History of aggression/violence:	Yes ❒ No ❒	
	Yes ❒ No ❒	

Has the client consented to this referral to CHMR Outreach Service? ❒ Yes

Please note: We will not act on referrals without consumer consent

Signature of referrer: _____Signature of consumer: _____

CHMR Office Use Only

Contacted by: _____ Date: _____

Appointment date: _____ Time: _____

Name of Counsellor: _____