CHMR – CONSUMER REFERRAL

Consumer Details

Given Name			Surname		
Known as		Gender		DOB	
Address					
Phone		Email			
Next of Kin name		Contact Number			
GP		Contact Number			

Previous contact with

☐ Milliya Rumurra	☐ KHMHDS	☐ DCPFS	☐ DOCS
☐ **Other** *(specify)*			

Reason for referral

Report Required	☐ Yes	☐ No

Substance use history

Mental health history

Currently taking medications	☐ Yes	☐ No	**History of violence or aggression**	☐ Yes	☐ No
Details			**Details**		

Offending history

Referrer Details

Referrer Name		Position	
Name of Service		Date	
Contact number		Email	

Please email or fax this form to:

E: chmrreception@cyrenianhouse.com
F: (08) 9192 8410 **P:** (08) 9192 6400