REFERRAL FORM
YOUTH TRIPLE C

Clare Medical Centre

Email: cmc@claremedical.com.au

CLIENT DETAILS				
NAME ON MEDICARE CARD LAST NAME :		FIRST NAME:		
CHOSEN NAME:	PRONOUNS:	DOB:	AGE:	Year Group if applicable
GENDER IDENTITY: ☐ Male ☐ Female ☐ Different than assigned at birth ☐ Other				
ADDRESS				POSTCODE
YOUNG PERSON'S PHONE NUMBER		YOUNG PERSON'S EMAIL		
ARE YOU OF ABORIGINAL OR TORRES STRAIT ISLANDER ORIGIN? - (select √ one) ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander				
COUNTRY OF BIRTH:	CULTURAL BACKGROUND:			Is an interpreter required Yes/No
GP:				Healthcare Card Yes/No
17 YEARS + EMPLOYED? ☐ No ☐ Yes Part-time ☐ Yes Full-time		17 YEARS+ INCOME SOURCE		

NEXT OF KIN		
NAME		
RELATIONSHIP		PHONE NUMBER
Would client like these involved in their care? YES/NO Is parent/carer aware of the referral? YES/NO	DCP involvement Yes/No Contact details	

ORGANISATION REFERER DETAILS	
ORGANISATION	
CONTACT PERSON	
PHONE NUMBER & EMAIL	

I CONFIRM THAT THE CLIENT CONSENTS AND IS AWARE OF THIS REFERRAL YES / NO

I CONFIRM THAT THE CLIENT AGREES TO EXCHANGE INFORMATION YES / NO

Signed: PRINT NAME: DATE :

ANY OTHER ORGANISATION INVOLVED	
ORGANISATION & CONTACT PHONE NUMBER/EMAIL	

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REASON FOR REFERRAL	
BRIEF DESCRIPTION OF MENTAL HEALTH ISSUE AND SUPPORT REQUIRED	

PROVIDE DETAILS OF RISKS ie

- **Alcohol & Any other substances**
- **Increase in risk taking behaviour**
- **Thoughts would be better off dead**
- **Thoughts or acts of hurting self or others in some way**
- **Recent significant life event**