MENTAL ILLNESS FELLOWSHIP of Australia (NT) Inc

Referral Form

Office Use ID#

Please complete pages 1 & 2. If question is irrelevant or information unknown, write NA
(To be completed either by the consumer/carer or by an agency together with the consumer/carer)

Referral Source ☐ Self ☐ Family/Friend ☐ Service Provider (name)		
Details of Person Being Referred ☐ Carer ☐ Consumer ☐ Child ☐ Other		
Name	Male ☐ Female ☐	DOB
Address	Mail Delivery Preference ☐ Email ☐ Post	
Phone Home Mob	Can leave a message? ☐ Yes ☐ No	Email
Do you have an NDIS package? ☐ Yes ☐ No ☐ Ineligible		
Cultural Background ☐ Indigenous ☐ CALD	Country of Birth	
Language Spoken at Home	Interpreter Required ☐Yes ☐ No	
Disability Access Required ☐ No ☐ Yes (specify disability)		
Other Dependents ☐ No ☐ Yes (specify numbers)		
Emergency Contacts 1) Name .....Phone.....Relationship..... 2) Name .....Phone.....Relationship.....		
Reason for Referral **(please attach any additional relevant documentation)**	☐ Respite (incl Karama Cottage, retreats) ☐ Education ☐ Individual Support ☐ Mi Place ☐ Mi Track ☐ Support Groups ☐ Cool Program ☐ Other	
Details of Person Significant to the Person Being referred **If referred person is a carer this section is about the person they care for** **If referred person is a consumer this section is about their carer** **If the referred person is a child or young person this section is about their family member**		☐ Carer/family member ☐ Consumer ☐ Other .....
Name	Male ☐ Female ☐	DOB
Relationship to Person Being Referred		
Address		
Phone Hm Mob	Email	
Cultural Background ☐ Indigenous ☐ Non Indigenous ☐ CALD (Culturally and Linguistically diverse)		
Disability Access Required ☐ No ☐ Yes (specify disability)		
Language ☐ English ☐ Sign ☐ Other (specify)	Interpreter Required ☐Yes ☐ No	
Other Dependents ☐ No ☐ Yes (specify numbers and ages)		

Consumer Information (for consumer listed on page 1)	
GP Psychiatrist/Psychologist	Name …….. Telephone No…… Name …….. Telephone No……
Top End (TEMHS) or Central Aust (CAMHS) Mental Health Service Details	Case Manager's Name …… Telephone ……
Current Primary Diagnosis:	Additional Diagnoses:
Psychiatric History	
Medical History	
History of Substance use	
Current treatment	
Current Symptoms	
Indicators of potential relapse	
Risk factors (include history of aggressive behaviour, potential risk to self or others, any forensic details)	
Legal Status	
Challenging behaviours and management strategies	

Consent to Referral	
Details of Person Referring	Name ……Date…… Name of Organisation ……Position …… Telephone ……Email ……
	I confirm that the person being referred has consented to this referral for Mental Illness Fellowship of Australia (NT) services. Signed ……
Consent of person (or guardian for Mi Track) being referred	I have discussed and understand that the information provided on this referral form will be provided to Mental Illness Fellowship of Australia (NT) Signed ……Date……