LIFE WITHOUT BARRIERS

CULTURALLY DIVERSE PSYCHOLOGICAL Service

General REFERRAL FORM

Eligibility: The service is for clients from a CALD background, 12 years and older with mild to moderate psychological presentations with barriers to accessing MBS psychological services. Individuals must reside in the Perth metropolitan area (Perth North and Perth South Primary Health Network areas).

Clients will receive short-term clinical intervention (up to 10 sessions) of culturally appropriate and evidence-based support from a psychologist or registered counsellor. Interpreters are used as needed. The service does not incur a fee.

Exclusions: The CDPS is not a crisis service and does not provide treatment for complex and severe mental illnesses, including personality disorders, psychotic disorders or complex PTSD.

CLIENT DETAILS

SURNAME				**FIRST NAME**			
GENDER	**MALE** ☐	**FEMALE** ☐	**OTHER** ☐	**DATE OF BIRTH**		**AGE**	
ADDRESS							
					POST CODE		
TELEPHONE	**MOBILE**			**WORK**		**HOME**	
EMAIL ADDRESS							
CLIENT CONSENT TO REFERRAL	**YES** ☐ **NO** ☐			**BEST TIME/SAFE TO CONTACT**		**SMS** ☐ **EMAIL** ☐ **PHONE CALL** ☐	
HEALTHCARE CARD	**YES** ☐ **NO** ☐			**CARD EXPIRY DATE**			
COUNTRY OF ORIGIN				**RESIDENCY STATUS IN AUSTRALIA**			
ETHNICITY				**RELIGION / SPIRITUALITY**			
LANGUAGES SPOKEN		**PREFERRED LANGUAGE**			**INTERPRETER NEEDED** **YES** ☐ **NO** ☐		
RELATIONSHIP STATUS				**OCCUPATION**			
IF CHILD, NAME OF CARER / LEGAL GUARDIAN				**CARER / LEGAL GUARDIAN CONSENT TO REFERRAL**	**YES** ☐ **NO** ☐		
CLIENT CONTACT NUMBER DIFFERENT FROM THE CARER/ LEGAL GUARDIAN	**YES** ☐ **NO** ☐			**CARER / LEGAL GUARDIAN CONTACT NUMBER**			

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General REFERRAL FORM

REFERRAL DETAILS

REASONS FOR REFERRAL			
PRIMARY DIAGNOSIS			
SECONDARY DIAGNOSIS/CO-MORBIDITIES			
MEDICATIONS (IF RELEVANT)			
SUICIDE IDEATION	YES ☐ NO ☐	LEVEL High ☐ Low ☐	
SELF HARMING BEHAVIOURS	YES ☐ NO ☐	LEVEL High ☐ Low ☐	
CLIENT RISK TO CHILDREN / OTHERS	YES ☐ NO ☐	If yes, details:	
LEGAL ISSUES / COURT ORDERS	YES ☐ NO ☐	If yes, details:	
CHILD PROTECTION INVOLVEMENT	YES ☐ NO ☐ OPEN ☐ CLOSED ☐	UNKNOWN ☐ UNKNOWN ☐	
OTHER SERVICES CLIENT REFERRED TO			
K10 SCORE **(if another test, please specify)**			
MHTP (please attach): Optional	YES ☐ NO ☐		

REFERRER DETAILS

NAME	
ROLE / PROFESSION	
PRACTICE / SERVICE	
ADDRESS	
TELEPHONE	
EMAIL ADDRESS	
REFERRAL SUBMITED ON	**(DD/MM/YYYY)**

A GP Progress Letter will be generated after 6 sessions and a GP Final Letter upon treatment closure (usually after 10 sessions).

Please email completed Referral Form to cdps@lwb.org.au