The CDPS Referral Form is available in the Best Practice Premier Software as CALD Psychological Service GP Referral Form.

CULTURALLY DIVERSE PSYCHOLOGICAL SERVICE
GP / Psychiatrist / Paediatrician 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 but requires a GP/medical referral.

Exclusions: Clients who are at high risk, or with complex and severe mental health illness, for example: psychotic disorders, personality disorders, bipolar disorder, complex PTSD, learning disorders, major drug and alcohol issues. This is not a crisis service.

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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GP / Psychiatrist / Paediatrician 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 CASE	YES ☐ NO ☐ UNKNOWN ☐ OPEN ☐ CLOSED ☐ 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

Mental Health WAPHA

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LIFE WITHOUT BARRIERS