BCH
Bass Coast Health

Counselling Referral

Surname .... U.R. No. ....
First Name .... Gender ....
Date of Birth ....../....../...... Age ....
Doctor .... Ward ....

PATIENT LABEL

PLACE LABEL HERE

Please scan and email to Bass Coast Health at:
access @basscoasthealth.org.au

Date of referral: ___ /___ /___

Name: ______________________ ☐ Client consent to referral

Address: ______________________

Phone: ______________________ ☐ Safe to text ☐ Safe to leave message

Email: ______________________

Emergency Contact Name: ______________________ Phone: ______________

Emergency Contact Relationship: ______________________ ☐ Consent to contact

Name of referrer: ______________ Designation: ______________ Phone: __________

Email: ______________________

SOCIAL, CULTURAL & FUNCTIONAL INFORMATION

Indigenous status: ☐ Not Aboriginal or Torres Strait Islander ☐ Aboriginal or Torres Strait Islander
☐ Aboriginal, not Torres Strait Islander ☐ Torres Strait Island, not aboriginal ☐ Not Stated

Cultural/Linguistic/Religious/Spiritual background ______________________

Interpreter required ☐ Yes ☐ No

Marital Status	Living arrangements/social	Carer Details
☐ Married/Defacto	☐ Alone	☐ No Carer
☐ Widowed	☐ With Family	☐ Co-resident carer
☐ Divorced/separated	☐ With others	☐ Non-resident carer
☐ Single	☐ Not stated	☐ Not stated
☐ Not Stated	☐ Socially Isolated	
	☐ Well supported socially	

Accommodation	Functional Impacts
☐ Own home/own rental	☐ Issues of communication
☐ Supported accommodation	☐ Issues of cognition
☐ Residential Care	☐ Issues of mobility
☐ Short term crisis or transitional housing	☐ Issues of continence
☐ Homeless / none	☐ Other significant issues ______________
☐ Not stated	______________________

Program:

☐ Generalist Counselling Service
☐ CHSP – Over 65 will require MAC referral
☐ Family Violence Counselling Service*
☐ Sexual Assault Support Service
☐ Other ______________________

*If referrer is RAE or ISE, referral will not be accepted without MARAM assessment and safety plan)

BCH, V2 May 2024

COUNSELLING REFERRAL

MR/315

BCH
Bass Coast Health

Counselling Referral

Surname .... U.R. No. ....
First Name .... Gender ....
Date of Birth ..../..../.... Age ....
Doctor .... Ward ....

PATIENT LABEL

PLACE LABEL HERE

CLINICAL INFORMATION

Reason/s for referral – Why Now? ____________________

Diagnosis – Physical + Mental Health + AOD ____________________

Treatment and response to treatment (eg. Additional referrals, current treatment plan, other agencies involved, falls precautions, routine haemodialysis etc) ____________________

Relevant medical, family and social history ____________________

RISK & PRIMARY PRESENTING SCREEN

Sexual Assault	☐ Recent <6 weeks	☐ <12 months	☐ Historical +12 months
Family Violence	☐ Recent <12 months	☐ Historical +12 months	☐ Pregnant
Suicidality ☐ Yes ☐ No	☐ Current	☐ Historical	
Recent mental health hospitalisation ☐ Yes ☐ No			
Alcohol & Other Drugs	☐ Current	☐ Historical	
Grief / loss	☐ +12 months	☐ <6 months	

Risk Profile ☐ IVO

☐ At risk of hospital admission ☐ Carer stress ☐ At risk of falls

☐ Behavioural issues ☐ Mental health concerns

☐ Anaphylaxis/allergies (detail) ____________________

☐ Adverse drug reactions ____________________

List actions taken to minimize risks ____________________

FORM COMPLETED BY:

Name ____________________ Signed ____________________

Designation ____________________ Date ____________________

COUNSELLING REFERRAL

MR/315

BCH, V2 May 2024