EUNITY

EUNITY LTD
MENTAL HEALTH REFERRAL FORM

Supporting Recovery • Preventing Relapse
Strengthening Communities

Phone
(07) 2140 2520

Fax
(07) 2140 2599

Email
info@eunity.org.au

Website
www.eunity.org.au

REFERRER DETAILS

Referring Practitioner Name:
Practice Name:
Provider Number:
Address:
Phone:
Fax:
Email:
Date of Referral:

CLIENT DETAILS

Full Name:
Date of Birth:
Address:
Phone:
Email:
Emergency Contact Name:
Emergency Contact Phone:
Medicare Number:
Expiry Date:

REFERRAL TYPE

- [ ] Mental Health Treatment Plan Referral
- [ ] Counselling Services

PRESENTING CONCERNS

- [ ] Anxiety

- [ ] Depression
- [ ] Stress
- [ ] Trauma
- [ ] Grief and Loss
- [ ] Emotional Distress
- [ ] Adjustment Difficulties
- [ ] Relationship Difficulties
- [ ] Social Isolation
- [ ] Low Motivation
- [ ] Chronic Health Condition
- [ ] Other:

REASON FOR REFERRAL

Summary of presenting issues and reasons for referral:

RELEVANT MEDICAL HISTORY

Brief overview of relevant medical conditions and history:

MENTAL HEALTH HISTORY

Previous Diagnoses:
Previous Mental Health Services:
Previous Hospital Admissions: [ ] Yes [ ] No
Details:

CURRENT MEDICATIONS

List current medications, including dosage and frequency:

CURRENT SUPPORTS

- [ ] Psychiatrist
- [ ] Psychologist
- [ ] Mental Health Social Worker
- [ ] Occupational Therapist
- [ ] Community Mental Health Team
- [ ] NGO Support Service
- [ ] NDIS Provider
- [ ] Other:
-

RISK INFORMATION

Current Suicidal Ideation: [ ] Yes [ ] No
Current Self-Harm Concerns: [ ] Yes [ ] No
History of Suicide Attempt: [ ] Yes [ ] No
Current Psychotic Symptoms: [ ] Yes [ ] No
History of Violence: [ ] Yes [ ] No
Current Safety Concerns:

IMPORTANT SERVICE INFORMATION

Eunity Ltd offers a range of community-based mental health services. For urgent concerns or crisis support, please contact your local mental health crisis team or emergency services.

CLIENT CONSENT

I confirm that the client has consented to this referral and the sharing of relevant information for the purpose of accessing mental health services.

Referrer Signature: _____ Date: _____

ATTACHMENTS INCLUDED

- [ ] Mental Health Treatment Plan
- [ ] Relevant Medical Reports

- [ ] Previous Assessments
- [ ] Other:

SUBMIT REFERRAL

Please submit completed referral forms via:

Email: info@eunity.org.au
Fax: (07) 2140 2599

If you have any queries, please do not hesitate to contact us.