Refugee and Asylum Seeker Mental Health Service

Community Referral
(for clients over 16 years of age)
NOT FOR GENERAL RELEASE

Unit Record No. _____

Surname _____

Given Names _____

DOB _____ Sex _____

AFFIX PATIENT IDENTIFICATION LABEL HERE

Return via **FAX:** 07 3163 8455 or **email:** mrccc@mater.org.au (preferred)

Patient details

Patient's first name _____
Patient's surname _____
Gender: ☐ Male ☐ Female
Date of birth _____ Age _____
Residential address _____
Suburb _____ State _____ Postal code _____
Home phone number _____ Mobile phone number _____
Country of birth _____ Date of arrival in Australia _____
Interpreter required? ☐ Yes ☐ No Language spoken _____
Ethnicity _____

Health insurance status

Asylum seeker: ☐ With Medicare ☐ Without Medicare ☐ With *Status Resolution Support Service* (SRSS) assistance

Medicare eligible? ☐ Yes ☐ No
Medicare number _____
Card reference number _____
Expiry date _____

Health Care card? ☐ Yes ☐ No
Health Care card number _____
Card reference number _____
Expiry date _____

Visa category

Residential status: ☐ Permanent resident ☐ Temporary visa holder ☐ Australian citizen ☐ Community detention
Time spent in detention _____ months _____ years

Community General Practitioner

Does the client have a GP? Yes / No
Has a referral been requested from the GP? Yes / No
GP Name:
Practice Name:
PH:

Does the client consent to being referred to this service? Yes / No

Return via **FAX:** 07 3163 8455 or **email:** mrccc@mater.org.au (preferred)

Reason for referral

Client requires an opinion regarding their mental health and well-being considering issues such as:

- ☐ Depression or problems with mood
- ☐ Anxiety
- ☐ Psychosis
- ☐ Trauma related issues or PTSD
- ☐ Substance Misuse
- ☐ Chronic concerns relating to suicidal ideation

Please include or attach an relevant supporting information to assist in appropriate prioritisation:

Referrer details

Date of referral _____ Organisation _____
Name of referrer _____
Position/ Role _____ Signature _____
Organisation address _____
Suburb _____ State _____ Postal code _____
Phone number _____ Fax number _____
Email address _____

Office use only

Date received _____ ☐ Entered into RHC database MRCCC referral meeting date _____
Category: ☐ 1 ☐ 2 ☐ 3 ☐ Accepted, date _____
☐ Pending, specify reason _____ Date to be revised _____
☐ Declined, specify reason _____ Date declined _____

UR number _____ Appointment letter sent to: ☐ Client ☐ Referrer
☐ Appointment booked for nurse health assessment Date of appointment _____
☐ Appointment booked with GP _____ Date of first appointment _____
Interpreter booked? ☐ Yes ☐ No