Military and Emergency Services Health Australia

Family and Individual Therapy

NAME: _____ **D.O.B:** ___/___/____
ADDRESS: _____
PHONE: _____ **EMERGENCY CONTACT:** _____

NAME OF PERSON SUBMITTING REFERRAL: _____
SERVICE NAME: _____ **PHONE:** _____
EMAIL: _____

Reasons for Referral _____

TREATING GP: _____ **PHONE:** _____

Clinical Diagnosis (if applicable) _____

Current Medications _____

Is there a crisis plan in pace **YES / No**
If yes please provide details _____

RISK ASSESSMENT
Please tick if any of the following apply and provide detail

Anxiety		
Depression		
Self-Harm		
Substance Abuse		
Post-Traumatic Stress		

Is the client aware of the referral? **YES / NO**

Care Management team/list services _____

Relevant Family History _____

Additional Information _____

Clients will have the option to participate in a research project funded by MESHA at their discretion.