

PLEASE EMAIL THIS REFERRAL TO CRS@360.org.au

NB: Not to be used if client is actively suicidal – Please refer to the nearest emergency department

Date: _____ Patient Name: _____ DOB: _____

Address: _____ Suburb: _____ Postcode: _____

Telephone: Home: _____ Mobile: _____ Gender: Male Female

Email: _____

Current mental health diagnosis: _____

Current psychotropic medications: _____

Any history of aggression? (if yes, please detail): _____

Current State and history of suicidal ideation, attempts and self-harm

Current psychosocial stressors

Other Clinicians and services involved with this patient? (Please list name and contact details)

Referrer Details (if not GP)
 Name, Service, Contact number

GP Details

Referral Consent: I _____ (patient name) have been briefed by my referrer & agree to be referred to ALIVE for suicide prevention counselling. I agree to information about my mental health & wellbeing being shared between my GP, 360 Health + Community & my counsellor & understand that records may be audited for quality improvement purposes.

Patient signature: _____ **Date:** _____

GP or referrer signature: _____ **Date:** _____

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