CGF006 ALIVE Suicide Prevention Counselling Referral Form

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 & welling 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**: _____