BCH
Bass Coast Health

Counselling Referral

Surname ..... U.R. No. .....

First Name ..... Gender .....

PATIENT LABEL

Date of Birth ...../...../..... Age .....

Doctor ..... Ward .....

PLACE LABEL HERE

Please scan and send via secure email to Bass Coast Health at:
access@basscoasthealth.org.au

Date of referral: ___ /___ /_____ ☐ Client consent to referral

Name: _____ Client Date of Birth: ___ /___ /_____

Address: _____

Phone: _____ ☐ Safe to text ☐ Safe to leave message

Email: _____

Emergency Contact Name: _____ Phone: _____

Emergency Contact Relationship: _____ ☐ Consent to contact

Name of referrer: _____ Designation: _____ Phone: _____

Email: _____

SOCIAL, CULTURAL & FUNCTIONAL INFORMATION

Indigenous status: ☐ Not Aboriginal or Torres Strait Islander ☐ Aboriginal or Torres Strait Islander

☐ Aboriginal, not Torres Strait Islander ☐ Torres Strait Islander, not aboriginal ☐ Not Stated

Cultural/Linguistic/Religious/Spiritual background _____

Interpreter required ☐ Yes ☐ No

Marital Status	Living arrangements/social	Carer Details
☐ Married/Defacto	☐ Alone	☐ No Carer
☐ Widowed	☐ With Family	☐ Co-resident carer
☐ Divorced/separated	☐ With others	☐ Non-resident carer
☐ Single	☐ Not stated	☐ Not stated
☐ Not Stated	☐ Socially Isolated	
	☐ Well supported socially	

Accommodation	Functional Impacts
☐ Own home/own rental	☐ Issues of communication
☐ Supported accommodation	☐ Issues of cognition
☐ Residential Care	☐ Issues of mobility
☐ Short term crisis or transitional housing	☐ Issues of continence
☐ Homeless / none	Other significant issues _____
☐ Not stated	_____

Program:

☐ Generalist Counselling Service

☐ CHSP – Over 65 will require MAC referral

☐ Family Violence Counselling Service*

☐ Sexual Assault Support Service

☐ Other _____

*If referrer is RAE or ISE, referral will not be accepted without MARAM assessment and safety plan)

COUNSELLING REFERRAL

MR/315

BCH3315

BCH, V3 Apr 2025

COUNSELLING REFERRAL

MR/315

Counselling Referral

Surname ..... U.R. No. .....

First Name ..... Gender .....

PATIENT LABEL

Date of Birth ...../...../..... Age .....

Doctor ..... Ward .....

PLACE LABEL HERE

CLINICAL INFORMATION

Reason/s for referral – Why Now? _____

_____

_____

_____

_____

_____

_____

_____

Diagnosis – Physical + Mental Health + AOD _____

_____

_____

_____

_____

_____

Treatment and response to treatment (eg. Additional referrals, current treatment plan, other agencies involved, falls precautions, routine haemodialysis etc) _____

_____

_____

Relevant medical, family and social history _____

_____

_____

_____

RISK & PRIMARY PRESENTING SCREEN

Sexual Assault ☐ Recent <6 weeks ☐ <12 months ☐ Historical +12 months

Family Violence ☐ Recent <12 months ☐ Historical +12 months ☐ Pregnant

Suicidality ☐ Yes ☐ No ☐ Current ☐ Historical

Recent mental health hospitalisation ☐ Yes ☐ No

Alcohol & Other Drugs ☐ Current ☐ Historical

Grief / loss ☐ +12 months ☐ <6 months

Risk Profile ☐ IVO

☐ At risk of hospital admission ☐ Carer stress ☐ At risk of falls

☐ Behavioural issues ☐ Mental health concerns

☐ Anaphylaxis/allergies (detail) _____

☐ Adverse drug reactions _____

List actions taken to minimize risks _____

FORM COMPLETED BY:

Name _____ Signed _____

Designation _____ Date _____

BCH, V3 Apr 2025