

Referral Plan

Please call before sending referral to ensure availability

Phone: 0438 816 367 Fax: 03 6343 0117

Email: coordinator@timeout.org.au

*Please ensure **all questions** are completed before forwarding*

Client Details

Client Name: _____

Date of Birth: _____

Residential Address: _____

Contact Number: _____

Emergency Contact Person: _____ Phone Number: _____

Relationship with Contact Person: _____

Referral Source

Name: _____

Organisation Name: _____

Contact No: _____ After Hours No: _____

Have you referred to Time Out before: Yes/ No

If No, How did you hear about Time Out? _____

Is client aware that mobiles and any sharps, or potentially dangerous items, will be locked away over the weekend? Yes/ No

Have you made the client aware of the conditions client contact? Yes/No

Background Information

Presenting Issues

<input type="checkbox"/>	Physical Abuse	<input type="checkbox"/>	Anxiety/Depression
<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	Self Harm
<input type="checkbox"/>	Pregnancy Testing and advice	<input type="checkbox"/>	Bullying
<input type="checkbox"/>	Sexual Abuse	<input type="checkbox"/>	Death or Loss Issues
<input type="checkbox"/>	Social Problems	<input type="checkbox"/>	Family Problems
<input type="checkbox"/>	Alcohol/Drug Abuse	<input type="checkbox"/>	Domestic Violence
<input type="checkbox"/>	Stress	<input type="checkbox"/>	Relationship Issues
<input type="checkbox"/>	Sexual Health	<input type="checkbox"/>	Physical Health
<input type="checkbox"/>	Sexual Identity	<input type="checkbox"/>	Youth Justice
<input type="checkbox"/>	Other _____	<input type="checkbox"/>	Other _____

Has the client attempted suicide in the last 30 days? **Yes/ No**

If yes, how many times, when was the last attempt, what method was used?

Is the client at risk suicide now? **Yes/ No**

Has the client attempted self harm in the last 30 days? **Yes/ No**

If yes, how many times, when was the last attempt, what method was used?

Is the client at risk self harm now? **Yes/ No**

Is the client utilising professional service? **Yes/No**

If yes who (e.g. counselling, mental health services)? _____

Does the client have a diagnosed mental health condition? **Yes/No**

If yes, what is the condition and their current treatments? _____

Is the client a risk of harming others?

Yes/No

Does the client have an issue with persons of either sex

Yes/No

If yes, please explain _____

Are you aware of substance usage issues?

Yes/No

If yes, what substance/s are being used _____

Is the client still using the above substance?

Yes/No

Is the client a flight risk?

Yes/No

Does the client smoke?

Yes/No

If yes please ensure they have adequate amounts for the weekend stay as we will not purchase cigarettes for clients.

Any other information that could be useful _____

Medication Advice

Please ensure that the client brings along their medication that is required for the weekend.

Current Medication (prescription & non prescription): _____

Treating Practitioner: _____

Please be aware that all medication is locked away until client asks it to be released.

Befrienders do not administer any medication.

List Known Allergies: _____

Weekend Arrangements

Arrival time is Friday 6.00pm & Sunday discharge is 6.00pm,

If you would like alternate times please note below and we will try and accommodate.

Method of transport to the house: _____

Who will be dropping the client to the house? _____

Method of transport from the house: _____

Who will be collecting at time of discharge? _____

Dietary requirements: _____

Any other comments: _____

Referral Signature: _____

Received By: _____

Date: _____

Date: _____