Referral Plan

Please call before sending referral to ensure availability

Phone: 0438 816 367 Fax: 03 6343 0117

Email: coordinator@timeout.org.au

Client Details

Client Name: ____

Date of Birth: ____

Residential Address: ____

Contact Number: ____

Emergency Contact Person: ___________________________________

Relationship with Contact Person: _____________________________

Referral Source

Name: ____

Organisation Name: ____

Contact No: ______________________ After Hours No: _________________

Date of Referral: ____

Have you referred to Time Out before: Yes/ No

Medication Advice

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

Current Medication: ____

Treating Practitioner: ____

Date of Prescription: ____

Please be aware that all medication is locked away until client asks it to be released. Befrienders do not administer any medication.

Dietary requirements/allergies: _______________________________

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Weekend Arrangements

Arrival time is Friday 6.00pm. If you would like to arrange an alternate time contact the coordinator.

Method of transport to Launceston: ____

Method of transport to the house: ____

If applicable who will be dropping the client to the house ___________________________

Sunday discharge is 6.00pm (latest time), do you want to arrange another time, if yes what time: ____

Who will be collecting at time of discharge: ____________________________________

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

Why is the client being referred to Timeout? __________________________________

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Has the client attempted self harm in the last 30 days? ___________________________

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

____

Is the client at risk self harm now? ____

Is the client utilising professional service, if yes who (e.g. counselling, mental health services)?____

____

Does the client have a diagnosed mental health condition? ______________________

If yes, what are their current treatments? ______________________________________

____

Is the client a risk of harming others? ____

Does the client have an issue with persons of either sex, if yes, which sex & why?

____

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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? ________________________________

Is the client a flight risk? ____

Any other information that could be useful____________________________________

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Please ensure all questions are completed before forwarding to the co-ordinator.

Referral Signature:

Date:

Received By (Co-Coordinator)

Date: