Townsville Head to Health Referral Form

Townsville HEAD TO HEALTH

Head to Health provides the following:

Referral is not required but helpful.

- immediate mental health support for people in distress
- short- or medium-term mental health and wellbeing support
- service navigation and helpful, relevant information.

Providing support for adults across Townsville.

Section 1

Referral for

Please select one type of support and preferred way of attending Head to Health.

☐ **Support for mental health distress or crisis**

- ◯ the person will attend in person
- ◯ for phone contact within 24 hours (inc wknds)
- ◯ for phone contact within 7 days

☐ **Information, advice, connection and referral for ongoing support, including telehealth access to psychiatry consultation**

- ◯ the person will attend in person
- ◯ for phone contact within 7 days

Referral date .....Time.....

Referrer details

Referrer name.....

Service .....

Provider number/link code .....
(if known)

Role/Relationship.....

Email.....

Phone/Fax.....

Person details

Full name.....

Preferred name .....

Gender..... Pronouns.....

Date of Birth.....

Street address.....

.....Suburb .....

Postcode..... No Fixed Address ☐

Phone/Mobile.....

Email.....

Preferred contact: ☐ phone ☐ email ☐ sms

Okay to leave: ☐ voicemail ☐ email ☐ sms

Interpreter required: ☐ Yes ☐ No

Language.....

Section 1 - continued

Emergency contact

Contact in the event of an emergency or if the referred person is unavailable

Primary contact.....

Relationship/role .....

Agency .....

Phone .....

Email.....

Preferred contact: ☐ phone ☐ email ☐ sms

Okay to leave: ☐ voicemail ☐ email ☐ sms

Consent to share information

The Privacy Act requires the applicant to sign this form giving their consent for the release of their information and details.

☐ *I give consent for **Townsville Head** to Health to seek and share information concerning matters related to this application, with relevant local services, the emergency contact outlined in this form, and other service providers relevant to this referral.*

Signature of person being referred:

..... Date .....

*The referrer agrees that all information submitted in this referral is an accurate reflection of the applicant's support needs, is correct with no information withheld and is necessary for **Townsville** Head to Health to fulfill its duty of care to service users, staff and other partner agencies.*

Referrer signature:

..... Date .....

Section 2

Reason for referral (please include perspective of both person and referrer; diagnosis and symptoms if known; context)

Please attach Mental Health Treatment if available OR complete referral information below

Psychological distress score (if completed) K10..... K5 .....

Information Assessment and Referral Decision Support Tool (IAR) score if known.....
(Visit https://iar-dst.online/#/)

Section 2 - Continued

Current treatment/medication

Other relevant history or important information (medical conditions, substance use, allergies)

Any safety issues (for the person or for others)

Health/social care supports – others involved

neami national
Improving Mental Health and Wellbeing

phn NORTHERN QUEENSLAND
An Australian Government Initiative

We acknowledge the Bindal and Wulgurukaba people as the Traditional Owners of the region and pay our respects to Elders past and present. We recognise that their sovereignty was never ceded and are committed to a positive future for the Aboriginal and Torres Strait Islander community.

We celebrate, value and include people of all backgrounds, genders, sexualities, cultures, bodies and abilities.