outback futures | allied & mental health community wellbeing

REFERRAL FORM

email to **support@outbackfutures.org.au**
fax: **07 2145 8025**

fill in online

Date of referral	DD / MM / YYYY

CLIENT INFORMATION

First Name		**Last name**	
Date of Birth	DD / MM / YYYY	**Gender**	☐ Female ☐ Male ☐ Other

CLIENT'S DETAILS (17 & over)

Please contact by ☐ phone call ☐ text ☐ email

Phone		**Email**	
Address			

PARENT/GUARDIAN DETAILS (16 & under)

Please contact by ☐ phone call ☐ text ☐ email

Name		**Phone**	
Email		**Address**	

ADDITIONAL PARENT (if custody arrangements are in place)

Please contact by ☐ phone call ☐ text ☐ email

Name		**Phone**	
Email		**Address**	

REFERRER INFORMATION

Name		**Profession/role**	
Agency		**Phone**	
Email			

REFERRAL DETAILS

Primary reason for referral (key presenting concerns, including severity, degree of urgency and any relevant history, medical/other diagnoses)	
Other relevant information	
Details and frequency of support from other service providers eg RFDS, NWRH, Qld Ed SLP, Qld Health OT, Guidance Officer, HOSES etc	
Requested service/s (if unsure leave blank)	☐ Psychologist ☐ Counsellor ☐ Mental Health Social Worker ☐ Occupational Therapist ☐ Speech & Language Pathologist

REFERRER TO COMPLETE

I have discussed this referral with the client or parent/guardian, who has provided verbal or written consent for this referral to be made on their behalf. I also understand that Outback Futures may contact me for further information.	**Name:** **Signature:** **Date:** DD / MM / YYYY

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