

## Referral Form

Muswellbrook Medicare Mental Health Centre is a free mental health support program for adults in the Upper Hunter Region. This service also supports carers of people experiencing mental health challenges.

### Referring Organisation Details

Organisation: \_\_\_\_\_ Contact Person: \_\_\_\_\_  
 Date: \_\_\_\_\_ Phone: \_\_\_\_\_

### Participant Details

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Preferred Method of Contact: \_\_\_\_\_ Pronouns: \_\_\_\_\_

Phone  Text  Email  Mail

All further questions are optional, your responses won't impact the participant's access to Muswellbrook Medicare Mental Health Centre.

Gender:  Female  Male  Non-Binary

Gender Fluid  Other (please specify)

Do they identify as LGBTIQSB+?  Yes  No

Relationship Status  In a relationship  Single  Unknown

Indigenous Status:  Aboriginal  Torres Strait Islander  Neither

Country of Birth:  Australia  Other (please specify)

Main Language Spoken:  English  Other (please specify)

Do they identify as Culturally and Linguistically Diverse?  Yes  No

In the labour force?  Yes  No  Unknown

Do they identify as a person with a disability?  Yes  No

If yes, please specify:  Autism  Cognitive  Hearing

Intellectual / Learning  Mental Illness  Physical  Speech

Vision  Other (please specify): \_\_\_\_\_



We acknowledge the Traditional Owners and Custodians of the land where we live and work and their continuing connection to land, water, sea and community. We pay respects to Australia's First Peoples, to their unique and diverse cultures, and to Elders past, present and future.

Inclusion is about the actions we take every day. We welcome, support, and celebrate diversity.

NDIS Participant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Principal Diagnosis	<input type="checkbox"/> Not diagnosed	<input type="checkbox"/> Affective Mood Disorder	<input type="checkbox"/> Substance use disorder
	<input type="checkbox"/> Psychotic Disorder	<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Eating Disorder
			<input type="checkbox"/> Other
Do they take medication for their mental health?	<input type="checkbox"/> Yes		<input type="checkbox"/> No

What are the primary reasons for referring the participant to Muswellbrook Medicare Mental Health Centre?

Are there any safety concerns for this person, including self-harm, suicidal thoughts, abuse, domestic violence, risk taking behaviours, harmful substance use, or any other challenges?

Is there anything else we should know?

Has the participant given verbal consent that they would like to engage with Muswellbrook Medicare Mental Health Centre, are willing to have their details stored in our system, and are willing to be contacted?  Yes  No

Date Consented:

If you are using a paper-based form, then please return this form to: [MMHCMuswellbrook@socialfutures.org.au](mailto:MMHCMuswellbrook@socialfutures.org.au)

**Muswellbrook Medicare Mental Health Centre Helpline**  
**1800 595 212**

**[socialfutures.org.au/medicarementalhealthcentre](http://socialfutures.org.au/medicarementalhealthcentre)**