

CONSENT

All Bridges services are voluntary
 Please confirm that you have client
 consent for this referral by Xing
 the appropriate box below

Written Consent
 Verbal Consent

Client Referral Form
PRIVATE & CONFIDENTIAL
Personal Details

Name		Date of Birth	
Address			
Does the person identify as Indigenous	<input type="checkbox"/> No <input type="checkbox"/> Yes	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Country of Birth	Preferred Language	Translator Required	<input type="checkbox"/> No <input type="checkbox"/> Yes
Please provide details of how the client wishes to be contacted by Bridges to arrange an appointment – multiple boxes can be X'ed			
<input type="checkbox"/> Phone No. 1	Can we leave a message on this phone?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Phone No. 2	Can we leave a message on this phone?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Most convenient time to call			
<input type="checkbox"/> Email Address	<input type="checkbox"/> Letter to home address		
<input type="checkbox"/> Letter to alternate address (please provide details)			

Services Required – you may X more than one box

- Bridges Psychology Practice – GP Mental Health Treatment Plan – Item 2710 required**
- Drug & Alcohol Treatment Service**
- Dual Diagnosis Clinic**
- Fresh Start – Quit Smoking Program**
- Mental Health Rehabilitation & Recovery Services**
- Drug & Alcohol Rehabilitation Program**

Reason for Referral - Other Information Relevant to Treatment (e.g. Diagnoses, Substances Used, Presenting Issues, Risks, etc). *Please attach any supporting documentation*

Is this referral part of an EPC or ATSI Health Check?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Is referral part of a JSA Employment Pathway Plan (EPP)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Person Making Referral

Name		Date of Referral
Organisation		Provider Reg. No (if GP)
Fax	Phone	Email
Signature		

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