



Gem Gardens Drop-in-Centre

11 Hospital Road
Emerald Q 4720

PO Box 393
Emerald Q 4720

Phone / Fax: 07 4987 6036

REFERRAL FORM

First Name: **Surname:**

Address:
.....

D.O.B:/...../..... **Gender:** **Male** **Female**

Home Phone:Mobile Number:

Diagnosis

- Schizophrenia and Psychotic or Delusional Disorders
(eg Drug Induced Psychosis)
- Mood Disorders
(eg Depression, Bipolar disorder, Post Traumatic Stress Disorder)
- Anxiety Disorders
(eg Generalised Anxiety Disorder, Obsessive Compulsive Disorder, Agoraphobia, Panic Disorder)
- Personality and Behavioural Disorders
(eg Antisocial, Borderline Disorder, Schizoid, Schizotypal Personality Disorder)
- Eating Disorders
(eg Bulimia, Anorexia)
- Other (please specify)

All Current Medications:
.....
.....

Do you have any physical illnesses (allergies, diabetes, asthma etc)? **Yes** **No**

If yes please describe and explain limitations
.....
.....

Are you currently under Case Management? **Yes** **No**

Case Mangers Name:

Case Mangers Contact Number:

Do you have a Psychiatrist? Yes No

Psychiatrist's Name:

Psychiatrist's Contact Number:

Do you attend a community clinic? Yes No

Have you had any psychiatric hospital admissions over the past three (3) years that have been longer than three (3) months in duration? Yes No

If so, please provide details

.....
.....

Do you know what your warning signs are when you are becoming unwell? Yes No

If so, please provide details

.....
.....

Are you currently involved with the justice system? Yes No

Are you currently on an involuntary treatment order (ITO)? Yes No

Do you have **current issues involving** drug use/abuse? Yes No

Do you have **current issues involving** alcohol use/abuse? Yes No

If yes, would you like support to address these issues? Yes No

Do you have contact with your family? Yes No

Are they supportive of your illness? Yes No

Please list who is supportive.....

.....

Do you want the people who *are* supportive involved in your care? Yes No

What are your hobbies/interests? (Please circle)

Sport	Swimming	Gym	Library	Chess	Exercise
Art & Craft	Ten Pin Bowling	Tennis	Movies	Pilates / Yoga	

Are your finances managed by Public Trust? Yes No

If yes, do you know your case workers name?

Where do you currently receive income from?

Paid Employment Disability Support Pension Newstart Parenting Allowance

Other (please state):

Do you have a Department of Housing application in place? Yes No

If yes, do you know you Department of Housing Application Number?

If no, would you like assistance to complete a Department of Housing (DOH) Application?
Yes No

Do you require an advocate to be present during our contact with you to determine your level of support? Yes No
(An advocate is a person to give support, encouragement and to speak on your behalf if needed)

If yes, do you have someone you know? Yes No

Name: Phone Number:

If you don't know someone we can give you a contact number and/or help you to obtain an advocate

Applicant's Name:

Applicant's Signature:

Date:/...../.....

Referrer's Name (Family, Friends etc):

Referrer's Signature:

Date:/...../.....