CatholicCare Social Services Hunter-Manning
DIOCESE OF MAITLAND-NEWCASTLE

Clinical Care Program Referral Form

Complete the referral form and submit to CatholicCare via email: *clinicalcare@catholiccare.org.au*

REFERRER DETAILS	
Date of Referral:	
Referrer Name:	
Role/organisation:	
Contact details:	Phone: Email:

CLIENT DETAILS	
Client Name:	
Client DOB:	
Gender:	
Contact numbers:	(H) (M)
Home Address:	
First Nations:	Aboriginal Torres Strait Islander Aboriginal & Torres Strait Islander Neither Aboriginal or Torres Strait Islander
Culturally and Linguistically Diverse (CALD):	☐ Yes ☐ No If yes, enter country / culture:
Australian Resident:	☐ Yes ☐ No
Country of birth:	
Main language spoken at home:	
Interpreter required:	☐ Yes ☐ No

CLINICAL DETAILS	
Medicare number:	Ref No.: Exp:
Hospital Medical Record Number (if known):	
Current Diagnosis:	
Current medication/treatment:	
Has IAR-DST questionnaire been completed?	☐ Yes ☐ No
Does the client have a current Mental Health Care Plan?:	☐ Yes ☐ No
General Practitioner detail:	Name of GP:
	Name of Clinic:
	Phone:
	Address:

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REASON/S FOR REFERRAL	
History and co-morbidities:	
What's happening now for the client? *(current symptoms and how they are impacting the client)*	
Has the client self-harmed, attempted suicide or experienced suicidal ideation?	
Previous services or interventions:	
Current services or interventions:	
Allergies:	

REPORTS/ASSESSMENTS		
Type of Report	Date of Report	Attached
		Attached: ☐ Yes ☐ No
		Attached: ☐ Yes ☐ No
		Attached: ☐ Yes ☐ No
		Attached: ☐ Yes ☐ No
		Attached: ☐ Yes ☐ No
		Attached: ☐ Yes ☐ No