HEALAN CENTRE

Client-Initiated Referral

CLIENT INFORMATION

Full Name :

Address :

Date of Birth : / /

Email :

Primary Phone No:

Gender :

Preferred Pronouns:

Medicare No:

Ref:

Expiry:

Current School:

Year:

Phone:

PARENT OR CARER DETAILS

Full Name :

Primary Phone No:

Email :

Relationship to Child:

Full Name :

Primary Phone No:

Email :

Relationship to Child:

Presenting Mental Health Difficulties:

Detail the initial symptoms, their duration, and frequency. Explain how these issues affect the daily life of the young person, such as in school, at home, or in social settings.

Health or Development Difficulties:

Risk Issues

Do you feel that the child is currently at risk due to their mental health difficulties they experience (e.g) deliberate self harm, suicidal, risk to others Yes ☐ No ☐

Is there a current Safety Plan? If Yes, please describe the details of the safety plan. Yes ☐ No ☐

OTHER AGENCIES OR CARE PROVIDERS

Agency:		**Primary Phone No:**	
Email :		**Last Engagement**	
Agency:		**Primary Phone No:**	
Email :		**Last Engagement**	

THANK YOU FOR SUBMITTING A REFERRAL

Kindly forward the referral details to info@healancentre.com