



Phone: (07) 3735 1168

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LIFE PROMOTION CLINIC

REFERRAL FORM

Referral Date: _____ Referring Hospital / Clinic: _____

CLIENT DETAILS:

First Name: _____ Surname: _____

D.O.B: ____ / ____ / ____ Medicare No: _____

Address: _____

Postcode: _____

Phone: _____ Mobile: _____

Psychiatric Diagnosis: _____

Current Medication: _____

History of self-harm: Yes / No

If yes, method(s) used: _____

Previous suicide attempt(s)? Yes / No If yes, how many? (number) _____

When was the most recent suicide attempt? (please provide date, if possible) _____

What method was used: _____

Who else is involved with treatment: _____

Medical History: _____

EXCLUSION CRITERIA:

- Under 18 years
- High Risk of Suicide
- Active Pschosis

REFERRER NAME: _____ Provider No: _____

SIGNATURE: _____

Contact Ph: _____ Fax No: _____