Griffith UNIVERSITY

Australian Institute for Suicide Research and Prevention
WHO Collaborating Centre for Research and Training in Suicide Prevention
National Centre of Excellence in Suicide Prevention
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LIFE PROMOTION CLINIC

PROFESSIONAL REFERRAL FORM

Referral Date: _____ Referring Hospital / Clinic: _____

PATIENT DETAILS:

Given Name: _____ Surname: _____

D.O.B: _____ Medicare No:_____ Expiry: _____ Ref:_____

Address: _____

Postcode: _____ Email address: _____

Phone: _____ Mobile: _____

Occupation: _____ Relationship Status: _____

Does the patient identify as Aboriginal or Torres Strait Islander: Yes / No

Please note the following acceptance criteria for the Life Promotion Clinic.

All patients will be contacted for an intake assessment prior to acceptance into the clinic.

Inclusion Criteria:
- Suicidal ideation
- Past suicide attempts
- Deliberate self-harming (recent)
- Recovery aims/goals

Exclusion Criteria:
- Under 18 years
- Acute risk to suicide
- Active psychosis
- Drug/alcohol impairment impacting ability to engage in therapy.

LPC does not provide case management, eating disorder management or drug and alcohol supports.

LPC does not offer Dialectical Behavioural Therapy or Ketamine trials.

If you are a GP referring to a Psychologist in LPC, please consider completing a Mental Health Care Plan along with this referral.

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? (Provide date, if possible) _____

Method(s) used: _____

Current suicidal ideation: Yes / No Plan Intent (Please circle)

Who are the stakeholders involved with treatment (include contact details): _____

_____

Please attach any current safety plan details in addition to this form.

Psychiatric Diagnosis: _____

_____

Previous history of psychological treatment: _____

_____

Current Medications: _____

_____

Medical History:_____

_____

Patient aims/goals: _____

_____

Specific risks or factors that may impact Care? _____

Is the patient aware of the referral: Yes / No

Referrer Name: _____

Provider No: _____ Signature: _____

Contact number_____ Email: _____

If not the treating GP:

GP name: _____

GP clinic: _____

Contact number: _____

☐ I have read and acknowledge the acceptance criteria for the Life Promotion Clinic.