Ungooroo Suicide Prevention Program
REFERRAL FORM

UNGOOROO ABORIGINAL CORPORATION

Please Note: This referral is not accepted until an Aboriginal Mental Health Worker has made direct contact with the referrer via phone, fax or email. If contact is not made by a worker within 3 working days, please call us on (02) 6571 5111.

Ungooroo's Suicide Prevention Program (SPP) is not a crisis service. If there are immediate mental health concerns for a person, please dial 000 or go to the closest hospital Emergency Department. For urgent concerns call the Mental Health Line on 1800 011 511.

STAFF USE ONLY			
Type of Referral: ☐ In person	☐ Fax	☐ Email	☐ Phone
Referral received on: ____/____/_____	At time: _____	By: _____ (initial)	
Confirmation fax sent ____/____/_____	At time: _____	By: _____ (initial)	

Section A: DETAILS OF PERSON

Has the person agreed to this referral? ☐ Yes ☐ No

(Please Note: referrals will not be accepted without the consent of the person)

Is the person Aboriginal or Torres Strait Islander? ☐ Yes ☐ No

(Please Note: this program is for Aboriginal and Torres Strait Islander people only)

FIRST NAME				SURNAME	
DATE OF BIRTH		AGE		MALE ☐	FEMALE ☐ OTHER ☐
ADDRESS					
SUBURB				POSTCODE	
PHONE				MOBILE	
EMAIL					

Which contact/s would the person prefer to use? ☐ Home ☐ Mobile ☐ Email

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EMERGENCY CONTACT			
FIRST NAME		SURNAME	
RELATIONSHIP TO PERSON			
ADDRESS			
SUBURB		POSTCODE	
PHONE		MOBILE	

REASON FOR REFERRAL (situation, background)

Ungooroo has both male and female Mental Health Care Workers. Please indicate if you would prefer
☐ Male ☐ Female

Section B: DETAILS OF REFERRER			
☐ Self ☐ Family ☐ Friend ☐ Organisation/Service			
NAME OF REFERRER		SURNAME OF REFERRER	
ORGANISATION			
ADDRESS			
SUBURB		POSTCODE	
PHONE (Home)		PHONE (Mobile)	
EMAIL			

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Does the person see any other services at the moment? ☐ Yes ☐ No
☐ Drug & Alcohol ☐ School Counsellor ☐ Other Counsellor ☐ Juvenile Justice
☐ Community Services ☐ Adult Mental Health ☐ CAMHS (Child and Adolescent Mental Health)
☐ Other (please specify)
Please list services accessed in the last 12 months:

Does the person have a regular GP? ☐ Yes ☐ No			
GP NAME			
GP PHONE NUMBER			
NAME OF PRACTICE			
ADDRESS OF PRACTICE			
SUBURB		POSTCODE	
Does the person have a mental health care plan? ☐ Yes ☐ No (if Yes please attach if possible)			

OTHER INFORMATION (if known)					
MEDICARE NO.		REFERENCE NO.		EXPIRY DATE	
HEALTHCARE CARD NO.				EXPIRY DATE	
PRIVATE HEALTH INSURANCE ☐ Yes ☐ No		HEALTH FUND			

Please fax or email referral to:
Email: intake@ungooroo.com.au
Fax: 6571 5777
Ph: 6571 5111