CHANGE OF MIND
THERAPEUTIC SOLUTIONS

Change of Mind -Therapeutic Solutions Counselling Services

Referral Date: ______________________

REFERRAL REQUIRED

☐ Individual Counselling	☐Clinical Psychologist	☐Psychologist
☐ Group Counselling	☐Mental Health Social Worker	☐ Any available worker

PATIENT DETAILS

Title:		Surname:		First Name:		
D.O.B:				Gender:		
Address:					Post Code:	
Phone:				Mobile:		

Country of Birth:					
Aboriginal:	YES	NO	Torres Strait:	Yes	No
First Language			Interpreter Required?	Yes	No
Next of Kin:					
Phone:			Mobile:		

INFORMAL SUPPORTS

Person	Relationship

FORMAL SUPPORTS

Agency	Services/Treatment Provided

REFERRALS DETAILS

Name				STAMP
Agency				
Address				
Suburb		Postcode		
Contact No				
Email				
Fax				

CHANGE OF MIND
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MENTAL HEALTH and HISTORY	
Presenting Issues *What are your current mental health issues*	
Mental Health History	
Medications	
Mental Health Diagnosis	
Your Goals	

RISK ASSESSMENT

Risk Assessment	Ideation	Thoughts	Plan
Suicide			
Self-Harm			
Harm to Others			
Other:			

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DRUG AND ALCOHOL (AoD)

Past AoD Use:	
Current AoD Use:	

FORENSIC HISTORY

Past Convictions:	
Current/Pending Convictions:	

CONSENT

Patient Consent			
I ____ have discussed all aspects of my assessment/plan with my GP and agree to my referral to Change of Mind – Therapeutic Solutions. I agree to my health information being shares with Change of Mind. We have agreed to review the plan on ____________________________ (DD/MM/YYYY).			
Signature		Date	

Referrer Consent (if applicable)			
I ____ have discussed the all aspects of the above assessment/plan and referral to Change of Mind – Therapeutic Solutions with my patient. We have agreed to review the plan on ____________________________ (DD/MM/YYYY).			
Signature		Date	