2 Carmody Street,
LOGAN CENTRAL QLD 4114
admin@harmonyplace.org.au
(07) 3412 8282

Referral Form

Harmony Place is a community-based not for profit organisation that provides culturally responsive services to strengthen the mental health and wellbeing of individuals and communities across Queensland. As part of the Access Community Services Clinical Practice Unit, Harmony Place provides a limited suite of clinical services to staff and clients across Access' programs and services.

What do we do?

- Clinical services for clients are delivered based on contractual requirements and/or individual program needs by consultation with Access Executive Managers.

  This includes:
  - Individual Therapy/Counselling
  - Group Therapy/Counselling
  - Psychological Assessment (including functional impact reports)
  - Specialised Support Coordination (NDIS)
  - Support Coordination (NDIS)
  - Care Coordination (Mental Health)
- Consultative support for staff/case workers who may be responding to clients with critical and complex needs (incidental debrief/case conferencing/assessment/case conceptualization/critical risk management).

Harmony Place is not an acute mental health crisis service. If you have any immediate concerns regarding the safety and wellbeing of a person, please call: Mental Health Emergency Response Line (MHERL) on 1800 555 788; Lifeline on 13 11 14; or Kids Helpline on 1800 55 1800. In an emergency, contact 000 immediately.

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REFERRAL INTAKE FORM

Please forward completed referral to admin@harmonyplace.org.au

Date of Referral: ____/____/____	**Individual consented to referral?** ☐Yes ☐ No (See attached)	
Person's Details:		
Name:	DOB: ___/___/___	Gender: ☐ Male ☐ Female ☐ Trans ☐ Intersex ☐ Non-Binary ☐ Other _____
Phone Number:	Email Address:	
Address:		
Cultural Identity:	Preferred Language:	
Do you identify with any of the following: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander ☐ Neither Aboriginal or Torres Strait Islander ☐ Culturally or Linguistic Diverse ☐ Not Stated	Do you identify with any of the following: ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Queer ☐ Asexual ☐ Heterosexual ☐ Pansexual ☐ Not Stated ☐ Other _____	
Preferred Contact: ☐ Phone ☐ Email ☐ SMS	Preferred Practitioner ☐ Male ☐ Female ☐ Either	
Emergency Contact Name: Relationship: Phone Number:		
Reason for Referral: ☐ Individual Therapy ☐ Group Therapy/Wellbeing Groups ☐ Psychological Assessment ☐ Specialised Support Coordination (NDIS) ☐ Support Coordination (NDIS) ☐ Care Coordination (Mental Health)		
Therapeutic Service Required:		
Psychologist: ☐ • Diagnosis • Assessment • Evidence Based Treatment of Severe and Complex Presentation		

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Counsellor: ☐ • Supportive Counselling • Therapeutic Support
Other: ☐ *Please Specify:*
Referrer Details:
Name:
Organisation & Position:
Address:
Email: | Phone Number:
Does the person have an existing GP Mental Health Treatment Plan OR NDIS Plan: ☐ Yes ☐ No ☐ NDIS
Is the person linked with any other services? ☐ Yes ☐ No Please specify:
Has this person been a previous participant of Partners in Recovery (PIR), Continuous of Supports (CoS), National Psychosocial Supports (NPS), Extended Transition Support Program (ETP), National Disability Insurance Team (NDIS), Personal Helpers and Mentors (PHaMS) or Day to Day Living (D2DL)? ☐ Yes ☐ No If so, where and when?
NDIS Details (if applicable):
NDIS Reference Number: NDIS Plan Start Date: NDIS Plan Review Date: Therapy Budget: How is the NDIS plan managed: ☐ Self-managed ☐ Plan Managed ☐ NDIA Managed Provide details: Organisation (if applicable): Name: Phone:

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Email:		
Please list any goals outlined in your NDIS plan in order for us to best support you in achieving these:		
Support required for:		
☐ Depression	☐ Mood instability	☐ Relationship issues
☐ Anxiety	☐ Adjustment issues	☐ Sexual assault
☐ Family issues	☐ Academic problems	☐ Other trauma
☐ Sexuality/sexual identity	☐ Disordered eating/body image	☐ Grief/bereavement
☐ Substance use	☐ LD/ADHD	☐ Psychoses/delusions
☐ Behavioural issues	☐ Memory/cognition problems	☐ Health concerns
☐ Pain management	☐ Other:	
Additional information: (P*lease include here any information which may be useful as background information to assist with the referral e.g. Mental Health, Drug and Alcohol, Vocational/Educational, Physical Health, including past/current risk assessments)*		

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CONSENT TO REFERRAL:

The **Harmony Place** Referral Form collects information to assist **Harmony Place** staff to help people get access to the services they need as quickly as possible. All information will be treated confidentially and will not be used for any other purposes than what is stated on our confidentiality statement and consent form (signed when the person arrives for their appointment).

✓ I am aware that this referral is being made. I understand that I can withdraw from this referral or from the referred service at any time.

✓ I consent to **Harmony Place** obtaining relevant information from government and community-based agencies, doctors and other allied health professionals, specifically relevant to my care whilst being a client of **Harmony Place**.

Signed: _____ Print Name: _____

Date: ____/____/____

If the person is under 16 years of age, authorisation should (where possible) also be provided by a parent/guardian/carer.

Signed: _____ Print Name: _____

Date: ____/____/____

***☐ VERBAL CONSENT HAS BEEN GIVEN ***