



Boab Mental Health Team Referral

Mental Health Counselling Please attach DASS 21 or K10

**Grow Strong Live Long
Suicide Prevention
Counselling (Kimberley –wide)** Please attach risk assessment information/K10

(Filling out the information below constitutes as a GP MH Treatment plan)

Referring Practitioner Details

Name: _____ Organisation _____

Postal Address: _____

Phone: _____ (wk) _____ (mobile) Fax: _____

Email _____ Referral Date: ___/___/___

Does your agency plan to have ongoing involvement with the client? Yes No

If yes, please name the Key Worker currently involved in client care:

Client Details

Name: _____ Date of Birth: ___/___/___

Gender: Male Female Medicare No: _____

Postal Address: _____

(Appointments are conveyed to clients via post)

Residential Address: _____

Phone: (home) _____ (mobile) _____ (wk) _____

Carer Details &/or emergency contacts _____

Other agencies involved in client care: _____

Cultural Background: Aboriginal Torres Strait Islander

Born overseas *please specify where* _____

Reason for Referral

Presenting Issues: _____

Boab Health Services Pty Ltd

Broome Office

Unit 5, 20 Hamersley Street | PO Box 1548 Broome, WA 6725

T 08 9192 7888 | F 08 9192 7999 |

Kununurra Office

Ochre Centre, 96 Coolibah Drive | PO Box 1866 Kununurra, WA 6743

T 08 9168 2560 | F 08 9168 3305 |

Patient History Please record any relevant psychological, & medical history (include issues re substance abuse)	
Medications/Known Allergies Provide details	
Social History List relevant factors including cultural factors	
Family History Provide details of any family history of mental disorders &/or relevant biological factors	
Results of Mental State Examination Record any results not in keeping with the norm	
Risks and Safety Note any associated risks of self harm &/or harm to others	
Requested Service What services/treatment do you anticipate we will provide?	
Assessment/Outcome Tools If any such tools have been used, attach a copy & comment on the results	K10: DASS 21: Edinburgh Post Natal Depression Scale: Risk Assessment Tool: (Copies can be downloaded from Boab Health Services web site or MMEX)

Please FAX this form to (08) 9192 7999

Grow Strong Live Long ATSI and Non ATSI suicide prevention counselling (Kimberley-Wide): One of our clinicians will attempt to contact the client within 48 hours to discuss the referral. Please ensure you provide an assessment of risk and a completed K10 if possible.

If you believe the client is in crisis, or requiring immediate assistance, please contact the Kimberley Mental Health Services in Broome 9194 2640, Derby 9193 3605 or Kununurra 9166 4350.

Referrals for mental health counselling are attended to in order of receipt to the Boab Mental Health Team. On receipt of referral, referrers and clients will be sent a letter to inform them of the estimated wait time for commencement of a clinical service. Clinical responsibility lies with the referrer until a clinical service commences.

**If you wish to discuss this referral or interim alternative options available within the community please contact the Boab Mental Health Team:
West Kimberley (Broome): 9192 7888 and East Kimberley (Kununurra): 9168 2560**