LikeMind is NOT a Crisis response service.
For emergencies dial "000" or alternatively dial the NSW Mental Health Line 1800 011 511

Service Provider Referral Form

LikeMind is a mental health service providing Triage, Assessment and Care Coordination for Mental Health Clients over 18 years of age. LikeMind provides access to a range of consortium partners who deliver onsite mental health, drug and alcohol, primary health, vocational and psychosocial services in one location.

Date of Referral: _____

Penrith Referral ☐
109 Henry St, Penrith 2750
Phone: 8880-8111 Fax: 8880-8112
Email: likemindpenrith@uniting.org

Seven Hills Referral ☐
Unit 4, 197 The Prospect Highway, Seven Hills 2147
Phone: 8806-3800 Fax: 8806-3887
Email: likemindsevenhills@uniting.org

Referrer Details

Contact Name & Organisation	
Contact Phone & E-mail	
Relationship to Client	

Client Details

Full Name			
Address			
Contact Number			
Date of Birth		Gender	
Dependents			

Does Client consent to referral? ☐ Yes ☐ No

Services Required
Psychologist ☐ Other, please specify ☐ _____
Psychiatrist ☐

Does the client have a current Mental Health Care Plan? Yes ☐ Number of sessions used _____
No ☐

Communication Issues/Interpreter Required? Yes ☐ No ☐ Specify_____

Pre-Existing Diagnosis (If the client has a pre-existing diagnosis please provide details of the diagnosis)

_____

_____

Current Presenting Issue (Please attach recent reports and or provide a comprehensive summary)

_____

_____

_____

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Has the client recently been in hospital due to psychiatric/psychological reasons? ☐ Yes ☐ No

Date _____ Location _____

Reason _____

Other services/professionals involved? ☐ Yes ☐ No

Details _____

Legal status/forensic issues (e.g. Criminal charges, AVO, guardianship, involuntary patient orders, fines)

_____

_____

Risk Factors (please provide details for any risk factors)

Suicidal ideation/behaviour ☐ _____

Non-Accidental Self Injury ☐ _____

Domestic Violence ☐ _____

Harm to Others ☐ _____

Substance Use ☐ _____

Homelessness ☐ _____

Gambling ☐ _____

Social Withdrawal ☐ _____

Significant health issues ☐ _____

Aggression towards staff ☐ _____

Referrer Signature:

Date:

Office Use Only Date Received: _____ Initials: _____ Walk-in ☐

Mastercare ☐ _____

Contact Referrer ☐ _____

Contact Client ☐ _____

Date of Assessment: _____

Rapid Risk Assessment **Clinician Notes:**

Suicide ☐ _____ _____

Self-Injury ☐ _____ _____

Other ☐ _____ _____

Safety Plan _____

_____