MyndKind Referral Form

Referred Person Consent

- Self-Referral ☐Yes ☐No
- If this is not self-referral

  Referred Person Consent for Referral:
  ☐Yes ☐No

  Referred Person Consent for **Mynd**Kind Staff to discuss referral information with referrer:
  ☐Yes ☐No

Referring Program

☐ **Mynd**Kind **Journey Coordinators Mackay**
Walking alongside a person's mental health well-being Journey with a strong focus on building a trusting relationship, understanding a person's needs, and connecting them with the range of services and supports they need. Journey Coordinators also focus on capacity building, psychoeducation, and supporting self-management.

Referred Person Information

Date of referral:	
First Name:	Last Name:
Address:	
Phone:	Email:
Preferred Contact Method Please specify: phone /email Additional Questions: ☐ Is it Ok to leave a voice message? ☐ Is it Ok to sent a text message? ☐ Is it OK to send Mail?	
Gender:	DOB:
Indigenous Status: Aboriginal ☐ Torres Strait Islander ☐ Australian South Sea Islander ☐ Does Not Identify ☐	
Country of Birth:	Main Language at Home:
Interpreter Required: Yes ☐ No ☐	
Does the referred person have a child/children Yes ☐ No ☐ no contact	
Is Child Safety Involved Yes ☐ No ☐	

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Emergency Contact	
Contact Name:	Relationship:
Phone Number:	Email
Consent to be contacted if we are unable to contact the referred person ☐Yes ☐No	
Reasons for Referral	
Please provide reasons for the referral:	
Other Information	
Does the referred person have a history of aggression or violence? ☐Yes ☐No If 'yes', please provide further information:	
Does the referred person have a history or current use of substances that may impact their engagement with support? ☐Yes ☐No If 'yes', please provide further information:	
Is the referred person currently having safety concerns related to suicidality or self-harm? ☐Yes ☐No If 'yes', please provide further information:	
Is the referred person currently experiencing safety concerns related to domestic and family violence? ☐Yes ☐No If 'yes', please provide further information:	
Does the referred person have any pets? ☐Yes ☐No If 'yes', please provide further information:	
Referrer Information (if Applicable)	
Name:	Organisation:
Role:	Phone Number:
Email Address:	
Will you have ongoing involvement with the referred person? ☐Yes ☐No	
Do you want to be involved in the initial conversation appointment? ☐Yes ☐No	

Please return completed referral form to

SteppedCareProgram@footprintscommunity.org.au