PCCS Plus Social®
referral form

By consenting to this referral, the person is consenting to the sharing of their personal information. The information contained in the referral is used by the Head to Health Phone Service to: (1) deliver assessment and referral services, (2) for monitoring, aggregate reporting and evaluation purposes to improve quality and access to care.
This information will be passed on to the recommended provider who will contact the person.

Please indicate the information in this form has been discussed with, and provided to, the patient: ☐ Yes ☐ No

Patient or Parent/Guardian/Carer consents to referral? ☐ Yes ☐ No

Referrer consents to the collection and storage of referrer details on internal database? ☐ Yes ☐ No

REFERRER DETAILS			
		Date of Referral	
Title & First Name		Last Name	
GP Practice/Organisation			
Address			
		Post Code	
Phone No.		Email	
Fax No.			

PATIENT / CLIENT DETAILS			
First Name		Date of Birth	
Last Name		Preferred Name	
Address			
		Post Code	
Phone No.		Email	
Health Care/Pension Card	☐ Yes ☐ No Expiry date:	Gender	☐ Male ☐ Female ☐ Other
Aboriginal or Torres Strait Islander status:	☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither		
Culturally & Linguistically Diverse (CALD)	☐ Yes ☐ No	Is an interpreter required?	☐ Yes ☐ No
Language spoken at home			
Is there a current Mental Health Treatment Plan in place? *(If yes, please attach to this referral)*	☐ Yes ☐ No		
Emergency Contact Name		Relationship to client	☐ Parent ☐ Guardian ☐ Carer
Phone Number			Other:

REFERRAL NOTES	
Mental health diagnosis	

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Medications	

KEY GOALS (what else do we need to know to support the individual moving forward)	
What are the individual's key goals, and hopes for engaging in the program? What are the individual's strengths and support systems? Is there anything you or the individual would like us to know about how we can best meet their needs? (e.g., cultural needs; medical; medication issues; developmental, functional; living skills; social; emotional; trauma, abuse and neglect; etc.)	

IDENTIFIED AREAS OF SUPPORT REQUIRED

☐ Emotional Wellbeing	☐ Social Connection	☐ Housing or Social Supports	☐ Families & Relationships	☐ Domestic Violence
☐ Physical Health / ADLs	☐ Food, Diet, or Lifestyle	☐ Financial Needs & Benefits	☐ Employment & Education	☐ NDIS & My Aged Care

SAFETY ALERTS - Are there any risk factors we should be aware of when visiting the home/client? For example if there is a history of aggressive behaviour?	☐ YES - please provide details below or attach risk assessment ☐ NO ☐ UNKNOWN
Please tick all that apply.	☐ Risk of harm to self ☐ Risk of harm to other ☐ Mental Health Order ☐ Enduring Power of Attorney ☐ Not able to make own decision / Guardianship ☐ Orders relating to children ☐ Intervention Order / AVO ☐ Triggers / Trauma
Please attach any plans/history	☐ YES – I am attaching relevant medical history and/or current treatment plans

Plus Social Clinical Care Coordination is a comprehensive, high intensity clinical support service for people age 18+ who experience the impact of severe mental illness and are not currently case-managed or accessing Gold Coast Health mental health services. Up to 26 weeks clinical care coordination and wellbeing program that is structured, recovery and goal orientated focused on creating significant improvements in quality of life, health and wellbeing.