

Please submit all referrals to pace@centacare.org.au.

Email or call Centacare's PACE Team, 8303 6660, for any questions or enquiries.

Referrer Information

Date:			
Name of referrer			
Referrer details	<input type="checkbox"/> GP <input type="checkbox"/> Mental Health Professional <input type="checkbox"/> Other (please detail):	<input type="checkbox"/> School <input type="checkbox"/> Self-referral	<input type="checkbox"/> Support Service <input type="checkbox"/> Family member
Contact details	Email	Phone	
How did you hear about us?			
Preferred method of contact?	<input type="checkbox"/> Phone	<input type="checkbox"/> SMS	<input type="checkbox"/> Email
Is the referred person aware of and consents to referral	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

Client details

Name	DOB	Pronouns
Address		
Contact details	Email	Mobile
Preferred method of contact?	<input type="checkbox"/> Phone	<input type="checkbox"/> SMS <input type="checkbox"/> Email
Emergency Contact	Name	
	Relationship	Phone
Cultural Identity	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Other (please detail):	<input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Culturally and Linguistically Diverse
Does the person require an interpreter?	<input type="checkbox"/> No	<input type="checkbox"/> Yes (please insert):
Additional information		
Are you (the client) at risk of homelessness?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Suicide ideation (current or previous)		
Self-harm thoughts and/or behaviours (current or previous)		

Reason for Referral

Support	<input type="checkbox"/> Groups <input type="checkbox"/> 1-1 Support
For Group Registration, provide info about the group, what to expect, and that someone will be in contact after the first session to check how the client felt it went.	
Groups/ Presentations	<input type="checkbox"/> Peer Support Group for eating disorder, body image, unhelpful relationship with food <input type="checkbox"/> other (please insert type):
For Individual Support, explain to client the amount of sessions provided, and level of support, allocation process. PACE's 1-1 support is not appropriate is already receiving support for the area of concern.	
1-1 Support	<input type="checkbox"/> Unhelpful relationship with food <input type="checkbox"/> Disordered eating <input type="checkbox"/> Body Image <input type="checkbox"/> Eating Disorder (please insert type):
Preferred type of support?	<input type="checkbox"/> Face to Face <input type="checkbox"/> Phone appointments <input type="checkbox"/> Online by Zoom
Client availability	
Carers (If Applicable)	<input type="checkbox"/> I am a carer, and my _____ has been experiencing (please detail):
What mental health concerns or symptoms have you been experiencing (currently or recently)?	
Are you currently or have you previously seen a mental health professional for diagnosis, treatment or support?	
<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, can you provide some details?	
Are there any potential barriers to accessing the service or any other relevant information we should know about?	
<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, can you provide some details?	

<i>For office use only</i>	
Date:	Worker (if applicable):