Multicultural Services Centre

MAITRI CLIENT REFERRAL FORM

MULTICULTURAL SERVICES CENTRE

1) Referrers Details

☐ Tick Box if Self Referred

Name: _____ Position / Title: _____

Organisation / Service Provider / GP: _____

Date of Mental Health Care Plan (Please fax to 9227 7638) _____

Phone: _____ Fax: _____ Email: _____

2) Client Details

First Name: _____ Surname: _____

Date of Birth: _____ Gender: _____

Phone: _____ Address: _____

Country of Birth: _____ Date of Arrival to Australia: _____

3) Emergency Contact / Next of Kin

First Name: _____ Surname: _____

Relationship to Client: _____ Phone: _____

4) Client Information

Reason for Referral: _____

_____

_____

Has the client been diagnosed with any mental illness? ☐ Yes ☐ No

Is the client currently receiving services: ☐ Yes ☐ No

If Yes please specify where: _____ Phone: _____

Has a mental health care plan been completed? ☐ Yes ☐ No

Has the client (or their legal guardian) agreed to this referral: ☐ Yes ☐ No

Has a risk assessment been completed (if yes please attach): ☐ Yes ☐ No

5) Consent to Referral

Client / Guardian Signature: _____ Date: _____

Referrers Signature: _____ Date: _____

Please email this form to maitri@mscwa.com.au or mail to PO Box 159, North Perth WA 6906