

# Consumer Referral Form (Medicare Mental Health only)

Please complete the details below to enable Lifeline to register your consumer on our system.

We provide outgoing calls for Low to Moderate risk consumers only. Please use more appropriate services if your consumer is at high risk.

Advise your consumer to expect the first scheduled call, and that the call will be from a private / blocked number. Direct your consumer to contact 1800 859 585.

**Please note, referrals are ONLY accepted by email to [AHSS@lifeline.org.au](mailto:AHSS@lifeline.org.au).** Referrals submitted by Medicare Mental Health and Neami National Intake and Assessment Coordinators do not require a practitioner form but must include an Initial Assessment and Referral Decision Support Tool (IAR-DST) assessment.

**Please complete all fields on this form to ensure consumer can access the service.**

PRACTITIONER AND CONSUMER DETAILS	
Referring practitioner name:	
Referring practitioner's profession:	Referring practitioner phone:
PHN network:	Business name:
Consumer name:	
Consumer phone number:	
Consumer address:	
Consumer date of birth: <i>dd/mm/yy</i>	Consumer country of birth:
Consumer gender:	Consumer disability status:
Consumer indigenous status: <input type="radio"/> Aboriginal <input type="radio"/> Non-Indigenous <input type="radio"/> Torres Strait Islander <input type="radio"/> Unknown <input type="radio"/> Aboriginal and Torres Strait Islander	
Consumer consent for AHS to: <input type="radio"/> Contact them <input type="radio"/> Leave a voicemail on the above number <input type="radio"/> To share their information with the referring/treating practitioner	

OUTGOING CALL DETAILS	
Would you like an outgoing call to be made to your consumer? <input type="radio"/> Yes <input type="radio"/> No	
Date first call to be made: <i>dd/mm/yy</i>	Frequency of calls:
Date last call to be made: <i>dd/mm/yy</i>	Preferred call time window: <i>e.g. 2pm - 5pm</i>
When is your next scheduled appointment with this consumer? <i>dd/mm/yy</i>	

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## REFERRAL DETAILS

Reason for referral (please describe the consumer's presentation and reason for referring to AHSS)

Current suicidal risk	<input type="radio"/> Yes	<input type="radio"/> No
Current suicidal thoughts	<input type="radio"/> Yes	<input type="radio"/> No
Current suicidal plan	<input type="radio"/> Yes	<input type="radio"/> No
Current suicidal intent	<input type="radio"/> Yes	<input type="radio"/> No
Suicide attempt in the last 3 months	<input type="radio"/> Yes	<input type="radio"/> No

Relevant history

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## OTHER RISKS

**Self-harm (Thoughts/Plan/Intent)**

Yes

No

**Relevant history**

**Risk to others (Thoughts/Plan/Intent)**

Yes

No

**Relevant history**

### **Current supports in place:**

*Formal supports:*

*Informal supports:*

**English level:**      Very well      Well      Not well      Not at all

**Interpreter required:**      Yes      No      If yes, specify which language required:

**Please return completed form by email to [AHSS@lifeline.org.au](mailto:AHSS@lifeline.org.au)**

For further information visit [suicidecallbackservice.org.au/health-professionals/AHS](http://suicidecallbackservice.org.au/health-professionals/AHS) or call 1800 859 585.