Reach Life

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Reach Life Referral Form

Referral date: ____/____/____

Please submit this form and any supporting documentation to admin@reachlife.com.au

Participant / Client details

Given Name(s): | Surname:

D.O.B: ____/____/____ | Phone:

Address: | Email:

Next of kin: | Relationship:

Preferred Contact Method: ☐ Phone ☐ Email ☐ Other: (please specify)

Interpreter required: ☐ Yes ☐ No

Referrer details

Full Name: | Phone:

Relationship: | Email:

☐ Client has been made aware that Reach Life is a private service and that out-of-pocket costs may apply when booking appointments.

Funding Type

☐ Medicare | Medicare Number: | IRN: | Expiry: ____/____/

☐ NDIS | NDIS #: | ☐ Plan managed

Invoicing email: | ☐ Self-managed

☐ Private / Other

Reason for Referral

Medical History

Current Diagnosis (If any):	Primary: ☐ Secondary: ☐
Presenting Issues:	☐ Depression ☐ Trauma ☐ Emotional Regulation ☐ Developmental Delay ☐ Anxiety ☐ Psychosis ☐ Bipolar ☐ Chronic Pain ☐ Stress ☐ Substance abuse ☐ Grief / loss ☐ Neuro-developmental Disorder ☐ OCD ☐ Relationships ☐ Personality Disorder ☐ Other
Current Therapy Supports:	
Other relevant medical history:	

Support Requirements

Self-care	
Mobility	
Communication	
Other	

Are there any behaviours of concern? If yes provide details: Include the behaviour of concern and any identified triggers. Behaviours may include (but are not limited to):

☐ Yes ☐ No

Behaviours	Identified Triggers	Behaviours	Identified Triggers
Wandering		Actions that may be perceived as intimidating	
Causing harm to self / others		Psychosis	
Inappropriate sexual behaviours		Other	
Property damage		What do behaviours look like on a worst day?	
Fears / Phobias		Are these behaviours current?	
Fixation		How have these behaviours been managed previously?	

Is there a current Positive Behaviour Support Plan? ☐ Yes ☐ No (If yes, please provide details)

For Referrals by GP / Paediatrician / Psychiatrist (ONLY)

Care Plan Type: ☐ Mental Health Care Plan ☐ Chronic Disease Treatment Plan

Dear Reach Life,

Please see above named client for _____ _____ sessions as part of their _____

(number of sessions) (group / individual) (MHCP / CDTP)

Provider Number:

Signature:

Stamp:

How did you hear about Reach Life?

☐ Online Search Engine (Google, Bing, Safari)
☐ Social Media
☐ Friend / Family
☐ Kismet
☐ Health Professional
☐ Other (please specify):