Lifeline Saving Lives
Crisis Support. Suicide Prevention.

SUICIDE AFTERCARE PROGRAM REFERRAL (page 1)

PERSONAL DETAILS OF PERSON TO BE REFERRED:

Surname: ________________________ First Name: ________________________________ Title: _______

Address: ___________________________ _____ Suburb: _______________________ Postcode:_______

Phone: (Landline): ____________________ (Mobile): ____________________

Email: ____Preferred method of contact: Home/Mobile

Date of Birth: _______________________ Gender: M/F/Other

Marital Status: Never Married/Married-De-Facto/Divorced/Separated/Widowed/Not Stated

Country of Birth: ____

Main Language Spoken at Home: English/Other ______________________________________

Does the patient require a language interpreter? ☐ YES ☐ NO

If YES, Language to be interpreted: _________________________________

Indigenous Status: Aboriginal/Torres Strait Islander/Aboriginal & Torres Strait Islander

Employment Status: Fulltime/Part-Time/Not Employed/Not Stated

PERSON'S CONSENT TO RECEIVE SUPPORT FROM LIFELINE:

Signature: ____ or

☐ Verbal Consent if person been referred is unable to provide written signature

CONSENT TO LEAVE A MESSAGE (If I'm not able to be contacted) (Tick all that apply)

☐ VOICEMAIL on preferred method of contact

☐ With another person

CONTACT DETAILS OF OTHER PERSON:

Name: ____ Telephone:_______________________

Relationship to person been referred:____

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SUICIDE AFTERCARE PROGRAM REFERRAL (page 2)

CONTACT DETAILS OF PERSON MAKING THE REFERRAL:

Date: ___________________

Full Name: _______________________________________Position:______________________________

Organisation:____________________________Suburb:_____________________Postcode:___________

Phone: Work: ____________Fax:________________

Email:____

Please attach a copy of the most current measure of psychological wellbeing (E.g. K10, K10+, DASS) if one is available

☐ K10

☐ K10+ (Preferred)

☐ DASS 21

Signature: _____________________________________ Date: _________________________

FAX Referral to: **02 4645 7250** or **Email to**: adminsp@lifelinemacarthur.org.au

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To discuss this referral contact: The Suicide Aftercare Coordinator on **4645 7200** or suicideaftercare@lifelinemacarthur.org.au

OFFICE USE ONLY:	
DATE REFERRAL RECEIVED:	RECEIVED BY: