Please email this referral to referrals@360.org.au
For further information, please call: 1300 706 922

NB: Not to be used if client is actively suicidal – please refer to nearest emergency department

ALIVE Suicide Prevention - Referral Form

CLIENT DETAILS			
Date:			
Client's legal name:			
Preferred name:		Preferred pronouns (he/she/they):	
Date of birth:			
Gender:			
☐ Man/Male	☐ Woman/Female	☐ Gender Diverse/ Non-Gendered	☐ Non-Binary
☐ Gender Fluid	☐ Prefer not to say	☐ Other	
Address:			
Suburb:		Post Code:	
Email:		Phone/Mobile:	
*PLEASE NOTE: At least one method of contact must be provided			
Relationship Status:			
☐ Single	☐ Married	☐ Defacto	☐ Separated
☐ Divorced	☐ Widowed		
Country of birth:			
Aboriginal/Torres Strait Islander Status:			
☐ Aboriginal	☐ Torres Strait Islander	☐ Aboriginal & Torres Strait Islander	
☐ Prefer not to say	☐ Neither Aboriginal nor Torres Strait Islander		

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CLIENT'S MENTAL HEALTH INFORMATION	
Please list client's current mental health diagnoses	
Please list any current psychotropic medication the client is taking	
Does the client have a history of aggression? (if yes, please detail)	
Briefly describe the client's current mental state and history of suicidal ideation, attempts and self-harm	
What are the current psycho-social stressors for the client?	
Other clinicians and services involved with this patient (please list name and contact details)	

360 health + community
BETTER ALL ROUND

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REFERRER DETAILS (if not GP)	
Name:	
Service:	
Contact Number:	
Email Address:	
GP DETAILS	
Name:	
Contact Number:	
Email Address:	

Referral Consent: I _____ have been briefed by my referrer & agree to be referred to the ALIVE program for suicide prevention counselling. I agree for information about my mental health & well-being to be shared between my referrer and/or GP and the 360 Health + Community ALIVE team. I understand that my records may be audited for quality improvement purposes.

_____ _____

Client signature Date

Referrer: I agree that I have informed the client about the intent of the ALIVE program and the commitment required by the client.

(*the client will need to be able to attend weekly counselling sessions at a regular day/time whilst with the ALIVE program. Flexibility is limited)

_____ _____

Referrer signature Date