Please submit all referrals to pace@centacare.org.au.
Email or call Centacare's PACE Team, 8303 6660, for any questions or enquiries.

Referrer Information

Date:			
Name of referrer			
Referrer details	☐ GP ☐ School ☐ Support Service ☐ Mental Health Professional ☐ Self-referral ☐ Family member ☐ Other: _____		
Contact details	Email		Phone
How did you hear about us?			
Preferred method of contact?	☐ Phone ☐ SMS ☐ Email		
Conflict of Interest	Does the referred person have an NDIS Plan? ☐ Yes ☐ No If yes, are they currently receiving NDIS Psychosocial Supports? (for Anxiety, OCD or Eating Disorders?) ☐ Yes ☐ No Details:_____		
Is the referred person aware of and consents to referral	☐ Yes ☐ No		

Client details

Name		DOB		Gender	
Address					
Contact details	Email		Mobile		
Preferred method of contact?	☐ Phone ☐ SMS ☐ Email				
Emergency Contact	Name Relationship		Phone		
Cultural Identity	☐ Aboriginal ☐ Torres Strait Islander ☐ Culturally and Linguistically Diverse ☐ Other:				
Does the person require an interpreter?	☐ No ☐ Yes - language:_____				
Additional information					

Reason for Referral

Support	☐ Groups ☐ 1-1 Support	
For Group Registration, provide info about the group, what to expect, and that someone will be in contact after the first session to check how the client felt it went.		
Groups/ Presentations-	☐ Eating Disorders Group-various location ☐ STARS Group- various location ☐ HOPE (OCD) Group - various location	☐ Relaxation, Mindfulness and Gratitude ☐ Breaking Free From Anxiety (BFFA) ☐ Be Bold ☐ Elephant in the Room ☐ Information Sessions
For Individual Support, explain to client the amount of sessions provided, and level of support, allocation process. PACE's 1-1 support is not appropriate is already receiving support for the area of concern.		
1-1 Support	☐ Anxiety: _____ ☐ OCD ☐ Eating Disorder: _____	
Preferred type of support?	☐ Face to Face ☐ Phone appointments ☐ Online by Zoom	
Client availability		
Carers (If Applicable)	☐ I am a carer, and my _____ has been experiencing: _____	
What mental health concerns or symptoms have you been experiencing (currently or recently)?		
Are you currently or have you previously seen a mental health professional for diagnosis, treatment or support?		
☐ No ☐ Yes If yes, can you provide some details?		
Are there any potential barriers to accessing the service or any other relevant information we should know about?		

For office use only			
Date:		Worker (if applicable):	