Mental Health Support Referral Form

About the Programs
The Multicultural Community Council Gold Coast (MCCGC) offers two culturally responsive, community-based mental health programs providing non-clinical psychosocial support:

- **Community Pathway Connector (CPC) - Entry level mental health supports**
  Funded by PHN, CPC offers short-term (up to 3 months) low-intensity support for individuals experiencing mild mental health challenges. This is typically the first point of contact for new clients or new clients being referred.
- **Culture in Mind (CIM) - Complex mental health challenges**
  In partnership with World Wellness Group and funded by the Queensland Health, CIM provides long-term, wraparound support for individuals with complex mental health needs. The program focuses on culturally responsive care that promotes recovery, inclusion, and community participation (up to 12 months).

All referrals are triaged by MCCGC to determine the most appropriate support and program allocation for you or your client.

In an Emergency
Please do **not** complete this form. Instead, call **000** for immediate assistance.

Experiencing a mental health crisis?
Call the Queensland Government mental health access line on **1300 MH CALL** (1300 642 255).

What you will need to complete this form:

- Contact details of the person being referred.
- Type of support or services you/they are seeking.
- Consent from a parent, guardian, or representative (if under 18), or from the person themselves if you are completing the form on their behalf.

After submitting the form, a member of our team will:

- Contact you to discuss your (or your client's) mental health needs.
- Reach out to the referred individual directly.

What happens with your information?
Your information is recorded in our customer database(s) so we can carry out and respond to your request. To learn more about our Privacy Policies, please visit: MCCGC Privacy Policy | WWG Privacy Policy

To help us process your referral appropriately, we require specific information relevant to the support being requested. All fields must be completed unless marked as (non-mandatory).

SUPPORT REQUIREMENT	
What type of support are you seeking?	***Please describe you or your client's support needs:*** *Include any relevant mental health concerns, known diagnoses, physical health issues, social or cultural factors, types of support needed, risks (e.g. suicide or self-harm), and other vulnerabilities. You may also note stress levels, emotional wellbeing, or life circumstances prompting the referral.*

REFERRER DETAILS (required)			
Date of referral	DD/MM/YYYY		
Referral Type	☐ Self-Referral (If selected, please proceed to 'Client Information' section ☐ Referral by Organisation		
Referral By Organisation			
Has your organisation obtained **Client Consent** for this referral?	☐ Yes ☐ No (if selected, the referral cannot proceed) *Please obtain the client's consent before initiating a referral. For assistance or questions, please contact the MCCGC Community Pathway Connector team via **07 5620 3900**.*		
Organisation Name			
Contact Person Full Name		Position / Role Title	
Phone		Email	

Form Abbreviation Reference:
NS/ID: Not Stated / Inadequately Described **N/A:** Not Applicable **U/UTD:** Unknown / Unable to determine.

CLIENT INFORMATION						
Salutation (Title)	☐ Mrs ☐ Ms ☐ Mr ☐ Master ☐ Doctor ☐ Other: …… ☐ NS/ID					
Given Name			Family Name			
Preferred Name			Date of Birth			
If under the age of 18 years, Parental / Guardian consent required to proceed.						
Parental consent required?	☐ Yes ☐ No - *if selected, provide reasoning:*					
Home Address	Building Name					
Unit / Street number		Street Name				
Suburb			State		Post Code	
Postal Address	☐ As above ☐ If different, specify below					
Home phone	( )		Mobile phone			
Email address			Referral source *(non-mandatory)*			
Sex	☐ Male ☐ Female	☐ Another term ☐ NS/ID	Gender	☐ Man / boy / male. ☐ Woman / girl / female ☐ non-binary	☐ Different term ☐ Prefer not to answer ☐ NS/ID	
Do you wish to identify as a member of the LGBTIQA+ community	☐ Yes ☐ No ☐ NS/ID – If yes, specify:					
Country of Birth *(non-mandatory)*			Religion *(non-mandatory)*			
Year of arrival in Australia *(non-mandatory)*			Interpreter / Language Support required	☐ Yes ☐ No ☐ NS/ID *If yes, please specify dialect:* ……		
Preferred language						
Additional language (1) *(non-mandatory)*						
Additional language (2) *(non-mandatory)*						
Ethnicity / cultural background:						

Indigenous status	☐ Aboriginal but not Torres Strait Islander origin ☐ Torres Strait Islander but not Aboriginal origin ☐ Both Aboriginal and Torres Strait Islander origin ☐ Neither Aboriginal nor Torres Strait Islander origin ☐ NS/ID		
Current visa type	☐Permanent ☐ Citizen ☐ Student ☐ Skilled / Work	☐ Temporary Protection (TPV) ☐ Special Humanitarian Enterprise (SHEV) ☐ Bridging – Seeking asylum ☐ Bridging - Other	☐ Partner ☐ No visa ☐ Unsure ☐ Other (if selected, please specify below)
	Please specify if Other selected:		
Medicare eligibility	☐ Yes ☐ No ☐ Unsure		
Financial hardship	☐ Yes ☐ No ☐ Unsure		

Does the client have any access requirements or need adjustments to participate in this service? *(e.g. mobility, sensory, communication - excluding language support)*	
☐ Yes - if selected, provided details ☐ No ☐ Unsure	*If yes, provide details:*

Does the client have any disabilities?	
☐ Yes - if selected, provided details ☐ No ☐ Unsure	*If yes, provide details:*

CONTACT PERSON(S)

Does the client have any Contact Person(s) and / or Emergency Contact(s)	☐ Yes – if selected, complete details below ☐ No – if selected, proceed to next section		
Contact Person (1)	NOMINATED REPRESENTATIVE ☐ Yes ☐ No / EMERGENCY CONTACT ☐ Yes ☐ No		
Full Name		Phone	( )
Relationship		Email	
Preferred Language *(non-mandatory)*		Address / Location *(non-mandatory)*	

Does the client currently utilise any other services providers or support relevant to their supports? If yes, provide below.

SERVICE PROVIDER DETAILS – (list any current service providers currently being used)

Is the client currently accessing any other service providers or supports related to their mental health?			
☐ Yes – if selected, complete details below ☐ No – if selected, proceed to next section			
Service Type	Contact Details		
	Name / Organisation:	P	( )
	Role / Relationship:	E	
	Name / Organisation:	P	( )
	Role / Relationship:	E	
	Name / Organisation:	P	( )
	Role / Relationship:	E	

Does the client consent for the MCCGC to contact the listed service providers for further information about their mental health support?
☐ Yes ☐ No

SIGNING
To the best of my knowledge, the information provided in this form is true and correct at time of completing.

Client / Referral Person

First Name		Last Name	
Signature	X	Date of completion	DD/MM/YYYY

Parent / Guardian / Representative (required if under the age of 18)

First Name		Last Name	
Relationship to Participant			
Signature	X	Date of completion	DD/MM/YYYY

Please email the completed form to healthtriage@mccgc.org.au or contact our team on 07 5620 3900 for additional information.

Thank you for your referral

OFFICE USE ONLY			
Date Received		Received By	
Program Allocation		Date of Allocation	
MCCGC Assigned Representative			
Notes			