FORM - CONFIDENTIAL REFERRAL

To be eligible for the MATES Program the applicant must:	yes / no
Be aged 18 years or older	
Be socially isolated	
Ready to expand social networks	
Have a mental ill health diagnosis	
Be actively working with a case manager or doctor regarding their mental health (and continue to do so during program)	

APPLICANT DETAILS			
Full Name:			
Address:		Suburb:	Postcode:
Phone:	EMAIL:		DOB:
Country of Birth:		Language spoken at home:	
Emergency Contact / Next of Kin - Name and Phone:			

IDENTIFIES AS: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Not Stated

GENDER: ☐ Female ☐ Male ☐ Transgender ☐ Intersex ☐ Other

What is the applicant's mental ill health diagnosis?

Describe in your opinion how/why the person is ready to reconnect?

Any physical conditions which should be taken into account? ☐ Yes ☐ No	
Details	

Any other comments or suggestions (anything the MATES coordinator should be aware of including alerts/concerns):

REFERRER DETAILS		
Name and Position:		
Agency / Organisation:		
Office Address:		
Will you be involved in the ongoing care of the participant?		
Office Phone:	Mobile Phone:	Email:
Backup Contact:	Backup Phone:	
Would the referrer or the referring agency like to be present at the first meeting between the MATES Coordinator and the applicant, if the applicant agrees? ☐ Yes ☐ No		

ONGOING MENTAL HEALTH CARE PROFESSIONAL'S DETAILS (Doctor, Psychologist, Psychiatrist)		
Name and Position:		
Agency / Organisation:		
Office Address:		
Office Phone:	Mobile Phone:	Email:
Backup Contact:	Backup Phone:	
Would the referrer or the referring agency like to be present at the first meeting between the MATES Coordinator and the applicant, if the applicant agrees? ☐ Yes ☐ No		

Referrals will not be accepted without adequate information regarding professional network of support and all details completed.

I agree to the referrer / mental health care professional releasing this information to Family Based Care Tasmania and for the referrer / mental health care professional to discuss this referral with Family Based Care Tasmania prior to making contact with me.

Applicant's Signature:	Date:

Please return this referral form to:

MATES Program

mates@familybasedcare.org.au

73 – 75 Mount Street
[PO BOX 510]
BURNIE TAS 7325