

MENTAL HEALTH LIAISON REFERRAL	
Date of referral	
Email to Mental Health Liaison at Health.COVIDMentalHealthLiaison@sa.gov.au	
Full Name:	
D.O.B	
Sex/Gender	
Mobile number Landline	
Address	
Isolation clearance date	
Reason for referral (ie current concerns, hx of mental health illness).	
Cultural considerations	Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Culturally and Linguistically Diverse Background <input type="checkbox"/> Interpreter required Yes <input type="checkbox"/> No <input type="checkbox"/> What language do they speak? English
Patient consent for referral	Yes <input type="checkbox"/> No <input type="checkbox"/>
Any additional information Re: referral.	
Referral contact details	Name: Position: Phone number: Email: