|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Partners in Recovery – Referral Form** | | | | | | | | | | | |
| All persons referred must have indicated a willingness to participate in PIR and are not in receipt of an  NDIS Individually Funded Package (IFP). | | | | | | | | | | | |
| Referrals can be made by phone **02 4708 8144** or fax **02 9673 6856** or email **PIR@nbmphn.com.au** | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | **Has this person indicated a willingness to participate in PIR?** ❑ YES ❑ NO | | | | | | | | | |  |
|  | **Referrer Details** | | | | | | | | | |  |
|  | Name of referrer: | | | | | | Date of Referral: | | | |  |
|  | Phone: | | | | | | Email: | | | |  |
|  | Organisation: | | | | | | Position: | | | |  |
|  | **Participant Details** | | | | | | | | | |  |
|  | Surname: | | | | | | First Name: | | | |  |
|  | Date of Birth: | | | | Or DOB estimate: | | | | | Gender: |  |
|  | Address: | | | | | | | | | Postcode: |  |
|  | Phone: | | | | Mobile: | | | | | Email: |  |
|  | Does the person have a Carer who supports them? ❑ YES ❑ NO ❑ UNKNOWN | | | | | | | | | |  |
|  | Carer Name: | | | | Carer Phone: | | | | | Carer Mobile: |  |
|  | Country of Birth: | | | | | | If not Australia, year of first arrival: | | | |  |
|  | Ethnicity: | | | | Main language spoken at home: | | | | | |  |
|  |  | | | | Interpreter required: ❑ YES ❑ NO | | | | | |  |
|  | Is the person a recipient of the Disability Support Pension where mental illness is the principal condition?  ❑ YES ❑ NO ❑ UNKNOWN | | | | | | | | | |  |
|  | **A&TSI Status** | | | | | | | | | |  |
|  | Please tick one of the following options: | | | | | | | | | |  |
|  | ❑ | Aboriginal but not Torres Strait Islander origin | | | | | | | | |  |
|  | ❑ | Torres Strait Islander but not Aboriginal origin | | | | | | | | |  |
|  | ❑ | Both Aboriginal and Torres Strait Islander origin | | | | | | | | |  |
|  | ❑ | Neither Aboriginal or Torres Strait Islander origin | | | | | | | | |  |
|  | ❑ | Origin not stated or inadequately described | | | | | | | | |  |
|  | **Questions on the Eligibility Criteria** | | | | | | | | | |  |
|  | **Does the person have severe and persistent mental health concerns, or have a diagnosis?** | | | | | | | | | |  |
|  | ❑ YES ❑ NO ❑ UNKNOWN | | | | | | | | | |  |
|  | If applicable, what is the diagnosis? | | | | | | | | | |  |
|  |  | | | | | | | | | |  |
|  | If there is no diagnosis, what are the concerns about the person's mental health? | | | | | | | | | |  |
|  |  | | | | | | | | | |  |
|  |  | | | | | | | | | |  |
|  | **Is there a principal mental health service provider?** ❑ YES ❑ NO | | | | | | | | | |  |
|  | If yes, please give details | | | | | | | | | |  |
|  | Name: | | | | | | Position: | | | |  |
|  | Organisation: | | | | | | Phone: | | | |  |
|  | **Does the person have any co-existing health concerns or disabilities?** | | | | | | | | | |  |
|  | ❑ | | Physical disability | | | | Specify: | | | |  |
|  | ❑ | | Intellectual/cognitive disability | | | | Specify: | | | |  |
|  | ❑ | | Speech/Sensory disability | | | | Specify: | | | |  |
|  | ❑ | | Drug and alcohol concerns | | | | Specify: | | | |  |
|  | ❑ | | Other | | | | Specify: | | | |  |
|  | If applicable, please give details of services involved: | | | | | | | | | |  |
|  | Organisation: | | | | | Worker: | | Phone: | | |  |
|  | Organisation: | | | | | Worker: | | Phone: | | |  |
|  | **Is the person currently receiving care co-ordination support?** ❑ YES ❑ NO | | | | | | | | | |  |
|  | If yes, who is providing this care co-ordination? | | | | | | | | | |  |
|  | Organisation: | | | | | Worker: | | Phone: | | |  |
|  | Worker: | | | | | | | | | |  |
|  | **Does the person have complex needs requiring services from multiple agencies?** | | | | | | | | | |  |
|  | ❑ YES ❑ NO ❑ UNKNOWN | | | | | | | | | |  |
|  | If yes, which needs does the person need help with? | | | | | | | | | |  |
|  | ❑ Housing | | | ❑ Drug & Alcohol | | | | | ❑ Homelessness | |  |
|  | ❑ Legal Services | | | ❑ Limited Family Support | | | | | ❑ Domestic Violence | |  |
|  | ❑ Other: | | | | | | | | | |  |
|  | If applicable, please give details of services already being accessed by this person: | | | | | | | | | |  |
|  | Organisation: | | | Worker: | | | | | Phone: | |  |
|  | Organisation: | | | Worker: | | | | | Phone: | |  |
|  | Organisation: | | | Worker: | | | | | Phone: | |  |
|  | Organisation: | | | Worker: | | | | | Phone: | |  |
|  | **Are there concerns about the person’s capacity to make decisions?** ❑ YES ❑ NO ❑ UNKNOWN | | | | | | | | | |  |
|  | If yes, please provide details: | | | | | | | | | |  |
|  |  | | | | | | | | | |  |
|  | **Other information relevant to this referral:** | | | | | | | | | |  |
|  |  | | | | | | | | | |  |
|  |  | | | | | | | | | |  |
|  |  | | | | | | | | | |  |
|  | **Please include any available supporting documentation** | | | | | | | | | |  |
|  | (e.g. mental health assessment care plan, discharge summary, up to date risk assessment) | | | | | | | | | |  |