|  |
| --- |
| **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) |  |