

Professional Referral Form



PARTNERS in RECOVERY
South Eastern Melbourne

Client Details

Name:	Given name:	Family name:
Date of Birth:	<input type="checkbox"/> Actual <input type="checkbox"/> Estimate	
Address:		
	Suburb:	Postcode:
Phone:		
Gender:	Marital status:	Children:
Country of Birth:	Language spoken:	Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No
Australian resident:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Pending <input type="checkbox"/> Other: (specify)	
Aboriginal/ Torres Strait Islander:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	
NOK name:	Phone:	
Does the client have a carer? :	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Other (specify)	
Is the client currently participating in the NDIS?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Referrer details

Referrer:	Agency:
Phone:	email:
Date of referral:	
Does your client meet the 5 criteria to be eligible for PIR?	<input type="checkbox"/> lives within the region (Greater Dandenong, Casey and Cardinia); <input type="checkbox"/> have a diagnosed mental illness (or evidence of) that is severe in degree and persistent in duration; <input type="checkbox"/> have complex needs that require services from multiple agencies; <input type="checkbox"/> doesn't have existing coordination arrangements or requires additional support to meet their needs; <input type="checkbox"/> have indicated willingness to participate in the PIR program.

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Mental Health /Medical History

Current mental health diagnosis:		Year of diagnosis:	
Mental health status:	<input type="checkbox"/> Formal <input type="checkbox"/> Informal	Last admission to hospital:	No of Inpatient admissions in last 2 yrs?
Medical history:			
D & A Substance issues:			

Accommodation

Details of Accommodation:	<input type="checkbox"/> Homeless <input type="checkbox"/> Private rental <input type="checkbox"/> Boarding house <input type="checkbox"/> Couch surfing <input type="checkbox"/> Living with family <input type="checkbox"/> Hospital <input type="checkbox"/> SRS <input type="checkbox"/> Other: (Specify)
Is the client's accommodation stable?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure

Education and Work History

Employment status:	<input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Studying
Source of Income:	<input type="checkbox"/> DSP <input type="checkbox"/> Newstart <input type="checkbox"/> Other pension <input type="checkbox"/> Employment income <input type="checkbox"/> Other (Specify)
Highest level of education:	
Transport:	<input type="checkbox"/> Licensed driver <input type="checkbox"/> Public transport <input type="checkbox"/> Friend and or family <input type="checkbox"/> Other (Specify)

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Risk history

Legal/ Forensic issues?

Any other risk factors?:
(including risk factors to staff safety –aggression/ threats/behavioural issues/environmental risks)

Other Professionals/Support services involved:

(Including names and contact details)

Name of Service

Contact Person

Contact Details

Summary of Client Needs:

- Accommodation
- Food
- Looking after the home
- Psychological distress
- Education
- Other (Specify)

- Self-care
- Daytime
- Physical health
- Psychotic symptoms
- Volunteering/Employment

- Cultural & Spiritual
- Safety to self/others
- AOD
- Relationship issues
- Financial/Benefits

Reason for referral:

Summary of current presentation

Is there any additional information we need to know?

Please provide any information you feel is relevant to support this referral (e.g., past assessments, discharge summaries, risks and alerts etc. Please add pages and attachments as required.)

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PIR Consent and Authority to Exchange Information

Name:	Given name:	Family name:
Date of Birth:	<input type="checkbox"/> Actual <input type="checkbox"/> Estimate	
Address:		
	Suburb:	Postcode:

I authorise and consent to information held by _____ pertaining to my:

- Personal history
- Health status
- Legal status

to be exchanged with **Partners in Recovery** for the purpose of referral to the program.

I consent to the referral and understand that this request can be withdrawn at any time.

Signature:			Date:
Witnessed by:			
Name:	Signature:	Date:	