Psychosocial supports are non-clinical and community-based supports that aim to support recovery in the community. This includes working with you, your family and carers to build capacity and stability including: socialising, financial management, accommodation support, job/ study goals, maintain health and wellbeing, managing substance issues. We are here to support you to increase confidence and be able to live as independently as possible.

### Please complete all the details below

### Section A – Consumer Information

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Personal details | | | |
| First name: | | Surname: | |
| Preferred name: | | DOB: | |
| Gender: | | Pronoun(s): | |
| 1. Contact details | | | |
| Phone:  Can we leave a voice mail? | | Mobile:  Yes  No | |
| Email: | |
| Address: | | Suburb: Postcode: | |
| 1. Consent for Referral | | | |
| Has the person being referred given permission to have the referral made on their behalf?  Applicants Name: | | Yes  No  Date: | |
| Applicants Signature: | | | |
| 1. Living arrangements | | | |
| Lives in own home  No fixed address  Social housing  ☐ Private rental ☐ Looking for housing ☐ Other (please specify): | | | |
| 1. Indigenous status | | | |
| Aboriginal Torres Strait Islander  Both Aboriginal & ☐Neither Aboriginal or Prefer not to say  Torres Strait Islander Torres Strait Islander | | |
| 1. Cultural background | | | |
| Cultural and Linguistic (CALD) background? | Yes  No | Interpreter required?  Yes  No |  |
| If ‘yes’, what is the preferred language? | | | |

|  |
| --- |
| 1. Dependants |
| Does the person have any dependants living with them?  Yes  No |
| 1. Income |
| Employed  Centrelink Name of Benefit being received (if known):  Other (please specify):  **CRN: Medicare Number:** |

### Section B – Other Supports

|  |  |
| --- | --- |
| 1. Carer information | |
| Does this person have a carer  Yes  No (if ‘no’ proceed to point 2) | Does the carer live with the person  Yes  No  Does the participant consent to exchange of information for referral purposes with carer  Yes  No |
| Carer name: | Carer phone: |
| Relationship to person: | |
| 1. Next of kin | |
| Name: | Phone: |
| Relationship to person: | |

|  |
| --- |
| 1. National Disability Insurance Scheme (NDIS) |

Select the box that best applies to the person being referred:

Is the person being referred currently registered for NDIS?  Yes  No

Has the person being referred tested for NDIS in the past?  Yes  No

If yes, what was the outcome:

**Please attach any supporting documents:**

|  |
| --- |
| 1. Current Supports |

**Is the person being referred currently receiving support from one or more of the following? (Please provide name of practitioners if known)**

Psychologist  Psychiatrist

GP  Counsellor

Community Mental Health  Other:

### Section C – Eligibility

|  |
| --- |
| 1. Eligibility Criteria of person being referred: |
| Is aged 16 or above  Not currently receiving similar Psychosocial supports  Not restricted in their ability to fully and actively participate in program (e.g. not currently in prison or hospital) Section D – Mental Health |
| 1. Diagnosis |
| This person has/appears to have a severe and persistent mental illness with associated psychological impact:  Yes  No  Primary mental health diagnosis and year of diagnosis:  Secondary mental health diagnosis and year of diagnosis:  **Mental Health Treatment Plan:**  Yes  No  **Medication for mental health:**  Yes  No  If yes, please specify:  Please attach relevant documentation ie: Discharge Summary, Care Plan, Mental Health Treatment Plan |
| 1. Risk Factors |
| **Any Current Suicidal risk factors: (please provide details how long ago, frequency)**  Suicidal ideations  Suicide attempts  Self-Harm  Additional Information:  Do you have a safety plan  Yes  No  If Yes Please attach documentation:  **Any hospitalisations for mental health in the last 3 years?**  Yes  No  If yes, please give details of hospitalisations including where, when and for how long:  **Any current or past aggressive or violent behaviour?**  Yes  No  If yes, please provide details:  **Any current legal matters?**  Yes  No  If yes, please provide details:  **Is there any current or past substance misuse?**  Yes  No  If yes, please provide details |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Section E – Referrer Details  |  |  | | --- | --- | | 1. Referrer information | | | Name: | Organisation: | | Relationship to person being referred: | | | Type of support provided: | | | Phone: | Fax: | | Email: | |   Section F – Reason for Referral |
| 1. Reason for Referral |
| Please describe the reason for referral: |
| 1. Support Needed |

**Are the applicant’s needs being met for the following:**

Social:  Yes  No Physical Health:  Yes  No

Accommodation:  Yes  No Financial:  Yes  No

Home maintenance:  Yes  No Personal Care:  Yes  No

Safety:  Yes  No Transport:  Yes  No

Cultural & Spiritual:  Yes  No

Other (please specify):

Section G – Health Information

1. Co-existing Health Factors

|  |  |  |  |
| --- | --- | --- | --- |
| Health issues | Sensory/speech disability | Dementia | Significant physical disability |
| Intellectual/cognitive disability | Acquired brain injury | Other (specify) | |

### Section G - Additional Information:

**Please add any other information you may consider relevant:**

### Eligibility process

Once a referral is received, an Assessment Officer will gather all relevant documentation and make an appointment with the participant to assess eligibility for the program. Once completed, the referral will be presented to an intake panel – both the referrer and referred applicant will be informed of outcome.

For more information call us on 1300 402 585.