Psychosocial Physical Health Pilot Program referral form

Thank you for referring your participant. To help us understand your participant's needs, please complete all sections of this referral form.

Date of referral:	Referrer name:	Referrer phone:
Referrer email:	Referrer's relationship to participant:	

Participant details			
Title:	Family name:	First name:	
Middle name:	Date of Birth:	Gender:	
Address:		Suburb:	
Postcode:	Phone:	Best contact method:	
Country of Birth:		Preferred language:	
Aboriginal and/or Torres Strait Islander: ☐ Yes ☐ No ☐ Unsure		Interpreter required: ☐ Yes ☐ No ☐ Unknown	
Is the participant a person with disability: ☐ Yes ☐ No ☐ Unsure		If yes, what is the nature of their disability:	
Smoking status: ☐ Smoker ☐ Non Smoker ☐ Unsure			

Emergency contact		
Name:	Relationship:	Phone:

Referral details
Presenting mental health diagnosis:

Presenting health diagnosis:

Is the participant linked to a Commonwealth Psychosocial Support Program (CPSP)? ☐ Yes ☐ No

Please state any other Mental Health Support Service engaged:

☐ Wellways ☐ Flourish Australia ☐ One Door Mental Health

☐ Medicare Mental Health Centre Wagga ☐ Community Mental Health ☐ Other _____

Current professionals involved (GP, specialists, Psychiatrist, Psychologist and/or support services etc.)

Current medications if known?

Has the participant been approved for NDIS?

☐ Yes – not activated ☐ Yes - activated ☐ No ☐ Pending ☐ Unsure

Does the participant experience one or more of the following challenges?

Does the participant have health related goals?	☐ Yes ☐ No ☐ Unsure
Does the participant have the ability and willingness to engage in short term (3 months) intensive supports to improve their health outcomes?	☐ Yes ☐ No ☐ Unsure

Please provide any relevant information that can assist us in supporting your participant in the most appropriate manner, and outline any barriers to accessing supports, any risks and outstanding health care needs or concerns:

Consent		
I consent to the referral being made on my behalf.		
Participant name	**Participant signature**	**Date**
Referrer name	**Referrer signature**	**Date**

Marathon Health is committed to protecting your information, and any information we collect is used to facilitate the services we provide to you.

- In providing high-quality services, we collect personal health information and maintain a participant record.
- We follow the Australian Privacy Principles (APPs) contained in the Privacy Act 1988 when handling, using and managing personal information.
- The APPs also outline your rights relating to accessing or correcting your personal information.
- We will not sell, transfer, assign or rent your information to any third party without your permission, unless required by law.

Referrer acknowledgement		
I have discussed the proposed referral to a health professional with the participant and/or authorised representative and am satisfied that the participant and/or authorised representative understands the proposed collection, use and disclosure of personal health information and has provided informed consent to the proposed collection, use and disclosure.		
Referrer name	**Referrer signature**	**Date**

Phone: 1300 402 585 **Email:** PPHPP@marathonhealth.com.au