Referral Form PIR Central Queensland

Partners in Recovery CENTRAL QUEENSLAND

Call us on (07) 4921 7777

PART A: DETAILS OF PERSON SUBMITTING REFERRAL FORM

DATE OF REFERRAL:

ORGANISATION:

CONTACT NAME:

CONTACT PHONE:

CONTACT EMAIL:

PART B: INDIVIDUALS INFORMATION

TITLE: ☐ MR ☐ MS ☐ MRS ☐ MISS Other, please specify:

FAMILY NAME:

GIVEN NAME/S:

DATE OF BIRTH:

CONTACT NUM/S:

EMAIL:

ADDRESS:

SUBURB/TOWN: POSTCODE:

CULTURAL BACKGROUND:

☐ Aboriginal ☐ Aboriginal/Torres Strait Islander

☐ Torres Strait Islander ☐ Non-Indigenous Australian ☐ Other, please specify:

☐ Culturally & Linguistically Diverse Background, please specify:

PART C: ELIGIBILITY

Does the person have a diagnosed severe and persistent mental illness/s?

☐ YES ☐ NO ☐ NOT KNOWN If yes, please specify:

Has the person been hospitalised (in the last 3 years) for treatment associated with diagnosed mental illness?

☐ YES ☐ NO ☐ NOT KNOWN

Is the Person a Disability Support Pension (DSP) recipient for mental illness?

☐ YES ☐ NO ☐ NOT KNOWN ☐ APPLICATION PENDING

One of the following MUST be included with your referral for confirmation of mental illness and diagnosis:

☐ Current Psychiatrist/Psychologist Report or Letter (completed in the past 3 years)
☐ Letter from General Practitioner or Specialist (completed in past 3 years)
☐ Report from Agency/Service responsible for clinical care (completed in past 3 years)
☐ Hospital Report or Discharge Summary (completed in past 3 years)
☐ Current/Pending DSP Report/Application with Mental Illness as the Principal Diagnosis
☐ Diagnosis to be arranged

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Please tick which needs the person has requiring support:

- ☐ Accommodation (housing, homelessness)
- ☐ Benefits/Income support
- ☐ Children
- ☐ Community/Social Connections
- ☐ Education &/or Training
- ☐ Employment &/or Volunteering
- ☐ Financial
- ☐ Food &/or Nutrition
- ☐ Mental Health
- ☐ Physical Health (primary or allied)
- ☐ Relationships
- ☐ Safety of Self/Others
- ☐ Self-Care
- ☐ Substance Abuse (addiction, misuse)
- ☐ Transport &/or Mobility
- ☐ Other, please specify: ____________

Please give further description on referring needs: (What would you like PIR to provide?)

PART E: COORDINATION SUPPORT

- ☐ AOD Services & Supports
- ☐ Advocacy Groups
- ☐ Counsellor
- ☐ Centrelink/Social Services
- ☐ Disability Services
- ☐ Dieticians/Nutritionist
- ☐ Education Services
- ☐ Employment Services
- ☐ Financial Services
- ☐ General Practitioner
- ☐ Housing Services
- ☐ Legal Services
- ☐ Natural Supports
- ☐ Primary Health Care Provider
- ☐ Personalised Support Services
- ☐ Psychologist/Psychiatrist
- ☐ Recreational/Community Groups
- ☐ Other Services (not listed)

Please name the services/family/carers/natural supports the person is currently accessing?

PART F: PARTICIPANT CONSENT

PRIVACY NOTICE: Central Queensland, Wide Bay, Sunshine Coast PHN as the Lead Agency for Central Queensland Partners in Recovery (CQ PIR) collects personal information contained within this referral form for the purpose of determining eligibility for the CQ PIR Initiative. The information may be disclosed to the appointed Support Facilitator Agency. Additionally as part of the activity the reporting requirements de-identified personal information may be disclosed to the Department of Health. Unless required by another state and national authority for legal reasons, the personal information of the Client will not be passed on to any third party without prior consent.

Has the Person or Legal Guardian approved disclosure of information associated with this referral? ☐ YES ☐ NO

Is the CQ Partners in Recovery permitted to contact the Person to discuss this referral? ☐ YES ☐ NO

A referral outcome will be provided to the referring agency.

Please select the preferred communication method. ☐ PHONE ☐ EMAIL ☐ LETTER

Participants Signature: ____________

PLEASE FORWARD FORM TO:

Email: pirrefcq@ourphn.org.au

Post: CQ Partners in Recovery

PO Box 312, Rockhampton 4700