# Partners in Recovery (PIR)

For more information please call 1300 747 724

# Referral Form – Clinical Staff

## DETAILS OF REFERRER

Name _____ Organisation _____

Position Title _____ Phone _____

## DETAILS OF PERSON BEING REFERRED

Name _____ Gender _____ DOB _____

Address _____

_____ Phone Number/s _____

Does the person identify as Aboriginal and/or Torres Strait Islander _____

Has the Partners in Recovery program been explained to the person? YES☐ NO☐

Has the person consented to this referral? YES ☐NO☐ **(if no, do *not* proceed with referral)**

Primary mental health diagnosis _____

Year the person was **first treated** for mental illness _____ Year the person was **last hospitalised** for their mental illness _____ Person's source of income_____

Does the person have a Carer? If yes, please provide name and contact details _____

_____

Does the person have a Case Manager? If yes, please provide name and contact details _____

_____

## REASON FOR REFERRAL TO PIR

Please tick boxes related to areas of concern for the person to demonstrate the complexity of the person's needs:

- ☐ Accommodation
- ☐ Food
- ☐ Looking after the home
- ☐ Self-care
- ☐ Daytime activities
- ☐ Physical health
- ☐ Alcohol and / or Drugs
- ☐ Social Isolation
- ☐ Community Engagement
- ☐ Child care
- ☐ Basic education
- ☐ Psychological distress
- ☐ Information on condition and treatment
- ☐ Financial
- ☐ Employment and volunteering
- ☐ Cultural and spiritual

## RISK FACTORS

Is the person at risk of harm to others? YES ☐ NO ☐

Is the person at risk of harm to self? YES ☐ NO ☐

Is the person on an Involuntary Treatment and/or Forensic Order? YES ☐ NO ☐

Please provide some detail:

_____

_____

_____

Where possible, please attach the following documentary evidence with the <u>person's consent.</u> Please tick to indicate:

- ☐ Info on treatment history and impact of treatment
- ☐ Impact of condition on everyday living skills
- ☐ WHODAS, HONOS, Life Skills Profile 16
- ☐ Discharge Summary
- ☐ OT assessments
- ☐ Psychological assessments
- ☐ Risk Assessments
- ☐ Reports from people who can describe impact of condition *(e.g. support workers, carers)*

Has the person consented to any of the above documents being attached with referral?

YES ☐ NO☐ **(if no, do *not* proceed with attaching)**

DATE OF REFERRAL: _____

Please fax completed forms to 07 5456 8147 or e-mail to pirref@ourphn.org.au