**Partners in Recovery Referral Form**

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| Partners in Recovery is a care coordination service for people with severe and persistent mental illness with complex needs, who require support from multiple services. Our Support Facilitators work with people to navigate the service system and to help them access the services they want, when and how they need them. |

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| **PARTICIPANT DETAILS** | | | | | | | |
| Name |  | | | | Main Language | |  |
| Other Names |  | | | | Need for Interpreter | | Yes  No |
| D.O. B |  | Age: |  | | CaLD | | Yes  No |
| Gender | Male  Female  Other: | | | | Aboriginal or Torres Strait Islander | | Yes  No |
| Address |  | | | | | | |
| Contact Details |  | | | | | | |
| NDIS Participant | Yes  No | | | Pension / Benefit Status Type: | |  | |
| Nature of Disability (if any) |  | | | | | | |

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| **GENERAL PRACTIONER (GP) DETAILS** | | | |
| GP Name |  | Clinic |  |
| Contact Details |  | | |

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| **REFERRERS DETAILS** | | | |
| Name |  | Date |  |
| Organisation |  | Role |  |
| Email |  | Phone |  |

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| **ELIGIBILITY CRITERIA** | | | | | | |
| The participant is experiencing severe and persistent mental illness. | Yes | No | Diagnosed  Undiagnosed | | | Unknown |
| The participant has complex needs that require services from multiple agencies. | | | | Yes | No | Unknown |
| The participant requires substantial support and assistance to engage with the various services to meet their needs. | | | | Yes | No | Unknown |
| There are no existing coordination arrangements in place to assist the person in accessing the necessary services, or where they are in place, those arrangements have failed, have contributed to the problems experienced by the participant and are likely to be addressed by acceptance into PIR. | | | | Yes | No | Unknown |
| Informed consent has been provided for referral to the PIR Program? | | | | Yes | No | Unknown |

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| **PRESENTING ISSUE(S) AS IDENTIFIED BY THE PARTICIPANT OR THEIR REPRESENTATIVE** |
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| **MENTAL HEALTH DIAGNOSIS / HISTORY** |
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| **SIGNIFICANT HISTORY** (Medical, physical health, medication issues, developmental, functional / daily living skills, social, emotional, trauma including abuse or neglect, etc.) |
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| **REASON FOR REFERRAL** |
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| **As the National Disability Insurance Scheme (NDIS) rolls out nationally, the Partners in Recovery program will ensure continuity of support to participants and assist eligible participants to transition to this new service.**   * I understand Partners in Recovery will support interested clients to test their eligibility for the National Disability Insurance Scheme (NDIS). * I have attached available documentation that would evidence long term/permanent mental illness and any functional impairment. |

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| **PLEASE FORWARD COMPLETED REFERRAL FORMS TO:** | | | |
| Email |  | Fax |  |
| **ACKNOWLEDGEMENT – COMPLETED BY SUPPORT FACILITATOR** | | | |
| Reviewed by |  | Date Received |  |
| Status of referral | Accepted  Wait listed  Not Accepted (note reason and suggest alternatives): | | |

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| **THANK YOU FOR YOUR REFERRAL** |