Personal Helpers and Mentors (PHaMs) Referral Form

Information collected on this referral form will determine program eligibility.

CUSTOMER DETAILS			
Name		Contact Number	
Address			Post Code:
Date of Birth		Age in Years	
Country of Birth		☐ Aboriginal or Torres Strait Islander ☐ Humanitarian Entrant (refugee)	
Language Spoken/s		☐ Lives Alone ☐ Family ☐ Other:	
Gender		☐ Prefers not to disclose	

CUSTOMER CONSENT

Referrer is required to obtain the Customer's consent to make this referral.

I_____ have requested support to participate in the PHaMs program and give my consent for this referral to be given to the PHaMs Program and all information in this referral is true and correct.

I do/do not (please circle appropriate one) give consent for PHaMs staff to make contact with the referrer.

Participant signature_____ Date _____

REFERRAL INFORMATION

Reasons for the referral to the PHaMs Program. What supports are required?
Does the customer have any medical conditions or disabilities? ☐ Yes – please provide details ☐ No

Has the customer ever been diagnosed with a mental illness?		☐ Yes ☐ No
Diagnosis	Who provided diagnosis?	When?
If no, what mental health concerns prompted the referral to PHaMs?		
Does the customer feel that their mental health concerns are stopping them from achieving what they want in life?		☐ Yes ☐ No
Does the person being referred currently use one or more of the following services?		
☐ Psychiatrist ☐ Social Worker ☐ Mental Health Nurse ☐ Psychologist ☐ Counsellor ☐ Case Worker ☐ Other: (community support programs, HACC etc)		
Does the customer's functional limitation prevent them from being able to make an informed decision to participate in the program?		☐ Yes ☐ No
Does the customer have a regular carer that provides support and assistance?		☐ Yes ☐ No
If yes –what type? ☐ Professional ☐ Family ☐ Friend		

RISK BEHAVIOURS

*Please note: the identification of any risk behaviours does **not** automatically exclude the person's ability to be referred*

Does the customer have any addictions?	☐ Yes ☐ No
Does the customer regularly consume alcohol?	☐ Yes ☐ No
If yes, how often/amount:	
Does the customer use tobacco?	☐ Yes ☐ No
Does the customer use illicit drugs?	☐ Yes ☐ No
If yes, please clarify:	
If yes to any of the above, is the customer willing to address the addiction?	☐ Yes ☐ No
Does the customer have a history of violent or aggressive behaviours?	☐ Yes ☐ No
If yes, please provide details:	
Has the customer recently been released from a prison or corrective institution?	☐ Yes ☐ No
If yes, is the customer restricted in their ability to fully participate in the community?	☐ Yes ☐ No
As a condition of release from the corrective institution, is the customer required to participate in a state/territory funded service that provides them with support similar to PHaMs?	☐ Yes ☐ No
Further Details:	

Does the customer have a history of self-harm, or have suicidal ideation/attempts?	☐ Yes ☐ No
What is the current level of suicide risk for the customer?	
☐ High Risk ☐ Medium Risk ☐ Low Risk ☐ High changeability Please include details, including the last time of occurrence:	
Is the customer currently homeless or at risk of homelessness?	☐ Yes ☐ No
If yes, please explain current living arrangements:	
Does the customer have a gender preference for PHaMs worker?	☐ Yes ☐ No
If yes: specify:	
Is there anything else we need to know about the customer ?	☐ Yes ☐ No
If yes, please provide details below:	

DETAILS OF REFERRING AGENCY			
Contact Person			
Agency Name		Phone No.	
Agency Address			
Fax No.		Email	
Signature		Date Referred	

Thank you for your referral please forward/send to:

Att: Personal Helpers and Mentors Program
E: albany@chorus.org.au
F: 98425987
P: 98926666
A: Unit 2, 63 Serpentine Road, Albany WA 6330

Date received by PHaMs _____ By : _____ Signature _____