

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 | <input type="checkbox"/> Aboriginal or Torres Strait Islander <input type="checkbox"/> Humanitarian Entrant (refugee) | | |
| Language Spoken/s | <input type="checkbox"/> Lives Alone <input type="checkbox"/> Family <input type="checkbox"/> Other: | | |
| Gender | <input type="checkbox"/> Prefers not to disclose | | |
| CUSTOMER CONSENT | | | |
| Referrer is required to obtain the Customer's consent to make this referral. | | | |
| <p>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.</p> <p>I do/do not (please circle appropriate one) give consent for PHaMs staff to make contact with the referrer.</p> <p>Participant signature _____ Date _____</p> | | | |
| REFERRAL INFORMATION | | | |
| Reasons for the referral to the PHaMs Program. What supports are required? | | | |
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| Does the customer have any medical conditions or disabilities? <input type="checkbox"/> Yes – please provide details <input type="checkbox"/> No | | | |
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| Has the customer ever been diagnosed with a mental illness? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diagnosis | Who provided diagnosis? | When? |
| | | |
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| If no, what mental health concerns prompted the referral to PHaMs? | | |
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| Does the customer feel that their mental health concerns are stopping them from achieving what they want in life? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does the person being referred currently use one or more of the following services? | | |
| <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Social Worker <input type="checkbox"/> Mental Health Nurse <input type="checkbox"/> Psychologist <input type="checkbox"/> Counsellor <input type="checkbox"/> Case Worker <input type="checkbox"/> 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? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does the customer have a regular carer that provides support and assistance? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes –what type? <input type="checkbox"/> Professional <input type="checkbox"/> Family <input type="checkbox"/> Friend | | |
| RISK BEHAVIOURS | | |
| <i>Please note: the identification of any risk behaviours does not automatically exclude the person's ability to be referred</i> | | |
| Does the customer have any addictions? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does the customer regularly consume alcohol? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, how often/amount: | | |
| Does the customer use tobacco? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does the customer use illicit drugs? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, please clarify: | | |
| If yes to any of the above, is the customer willing to address the addiction? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does the customer have a history of violent or aggressive behaviours? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, please provide details: | | |
| | | |
| | | |
| Has the customer recently been released from a prison or corrective institution? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, is the customer restricted in their ability to fully participate in the community? | | <input type="checkbox"/> Yes <input type="checkbox"/> 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? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Further Details: | | |
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|---|--|------------------------------|-----------------------------|
| Does the customer have a history of self-harm, or have suicidal ideation/attempts? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| What is the current level of suicide risk for the customer? | | | |
| <input type="checkbox"/> High Risk <input type="checkbox"/> Medium Risk <input type="checkbox"/> Low Risk <input type="checkbox"/> High changeability | | | |
| Please include details, including the last time of occurrence: | | | |
| | | | |
| | | | |
| Is the customer currently homeless or at risk of homelessness? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, please explain current living arrangements: | | | |
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| | | | |
| Does the customer have a gender preference for PHaMs worker? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes: specify: | | | |
| Is there anything else we need to know about the customer ? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, please provide details below: | | | |
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| 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: phams.albany@chorus.org.au
 F: 98425987
 P: 98926666
 A: Unit 2, 63 Serpentine Road, Albany WA 6330

Date received by PHaMs _____ By : _____ Signature _____