National Psychosocial Support (NPS) 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 ☐ Torres Strait Islander ☐ Both ☐Neither ☐ 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 NPSM program and give my consent for this referral to be given to the Chorus and all information in this referral is true and correct.

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

Participant signature_____ Date _____

REFERRAL INFORMATION

Is the customer currently receiving support through			
☐ Partners In Recovery ☐ Personal Helpers & Mentors ☐ Day to Day Living ☐ NDIS			
Reasons for the referral to the NPSM Program. What supports are required?			
Does the customer have any medical conditions or disabilities? If Yes, please provide details:			☐ Yes ☐ No
Has the customer ever been diagnosed with a mental illness?			☐ Yes ☐ No
Diagnosis		Who provided diagnosis?	When?
Primary Diagnosis			
Additional Diagnosis			
If no, what mental health concerns prompted the referral to NPSM?			

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	
Does the customer feel that their mental health concerns are stopping them from achieving what they want in life?	☐ Yes ☐ No
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? If yes, please provide details:	☐ Yes ☐ No
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 NPSM?	☐ 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? Please include details, including the last time of occurrence:	
☐ High Risk ☐ Medium Risk ☐ Low Risk ☐ High changeability	
Is a current safety plan available? (If yes, please attach)	☐ Yes ☐ No
Is the customer currently homeless or at risk of homelessness?	☐ Yes ☐ No
Please provide an overview of customers current living arrangements:	

Is there a history of any behaviour that would indicate the need for 2 staff?	☐ Yes ☐ No
Is the customer known to have visitors who would indicate the need for 2 staff?	☐ Yes ☐ No
Does the customer live in an area or situation that may place the staff member at risk?	☐ Yes ☐ No
Does the customer have a gender preference for NPSM 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		Role	
Agency Name		Email	
Agency Address			
Phone No.		Fax No.	
Signature		Date Referred	

Thank you for your referral please forward/send to:

ALBANY
E: albany@chorus.org.au
F: 9842 5987
P: 9892 6666
A: Unit 2, 63 Serpentine Road
Albany WA 6330

BUNBURY
E: bunbury@chorus.org.au
F: 9467 6184
P: 9792 6777
A: Unit 5A, 53 Victoria Street
Bunbury WA 6230

MANDURAH
E: mandurah@chorus.org.au
F: 9467 6184
P: 9550 4577
A: 98 Mandurah Terrace
Mandurah WA 6210

Date received _____ By : _____ Signature _____