Psychosocial Support Referral Form

Information collected on this referral form will determine program eligibility.

APPLICANT DETAILS					
Name		Contact Number			
Address			Post Code:		
Email					
Date of Birth		Age in Years		Gender	☐ Male ☐ Female Other:
Residency Status	Australian Citizen - Yes ☐ No ☐			Preferred Pronoun	
Cultural Identity	☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐Neither				
Country of Birth		Main Language Spoken			
MHTP - Mental Health Treatment Plan completed by GP	☐ Yes ☐ No	If yes, number of sessions used this year			
Employment	☐ Employed ☐Unemployed ☐ Not in the Labour Force ☐Not stated/inadequately described				
Employment type	☐ Full-time ☐ Part-time ☐ Not in the labour force ☐ Not stated/inadequately described				
Income	☐ Disability Support Pension ☐ Other pension or benefit (not superannuation) _____ ☐ Paid employment ☐ Compensation payments ☐ Other (e.g. superannuation, investments etc.) ☐ Nil income ☐ Not known ☐ Not stated/inadequately described				
Marital Status	☐ Never married ☐ Widowed ☐ Divorced ☐ Separated ☐ Married / De facto ☐ Not stated/inadequately described				
Emergency Contact					

All sections must be completed:	
Current NDIS Status:	
Does the Applicant require assistance to submit/re-submit NDIS Application?	☐ **Yes** ☐ **No**
Has the Applicant previously tested their NDIS eligibility?	☐ **Yes** ☐ **No**
Did the Applicant receive assistance to submit previously?	☐ **Yes** ☐ **No**
Does the Applicant have medical evidence that was submitted previously or the capacity to obtain medical evidence?	☐ **Yes** ☐ **No**

Does the Applicant have severe episodic mental illness with associated impact on psychosocial functioning?	☐ **Yes** ☐ **No**
Would the Applicant benefit from the CPS Program – Short term (12 week), goal based, 1:1 supports, or group supports?	☐ **Yes** ☐ **No**
What short term goal would the Applicant like to work on?	

What is the applicants' current level of distress?	☐ **High** ☐ **Medium** ☐ **Low**
Please share any additional relevant information:	
Current Accommodation status: please tick **Yes/No** below as applicable	
Does the applicant have stable accommodation?	☐ **Yes** ☐ **No**
If **No,** is the applicant engaged with accommodation services?	☐ **Yes** ☐ **No**
If **Yes,** please provide further details of current engagement and services being accessed:	
Is the applicant currently engaged with **Community Mental Health Services**?	☐ **Yes** ☐ **No**
If **Yes**, please provide details & duration of engagement:	
Is the applicant currently engaged with **other Psychological Services**?	☐ **Yes** ☐ **No**
If **Yes**, please provide details & duration of engagement:	
Is the Applicant currently receiving support from any other services?	☐ **Yes** ☐ **No**
If **Yes**, please provide details:	

ADDITIONAL REFERRAL INFORMATION

Has the applicant 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 this referral for psychosocial support?			
What psychosocial supports are required?			
Does the applicant have any medical conditions or disabilities?			☐ **Yes** ☐ **No**
If **Yes**, please provide details:			

Does the applicant have any current Alcohol and/or Other Drug (AOD) issues?	☐ **Yes** ☐ **No**
If **Yes,** please provide details of issues and of the AOD supports that the applicant is currently engaged with:	
Does the applicant have any Cultural considerations with regards to receiving services?	☐ **Yes** ☐ **No**
If **Yes,** please provide relevant details:	

RISK BEHAVIOURS

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

Does the applicant have a history of self-harm?	☐ **Yes** ☐ **No**
Does the applicant have a history of suicidal ideation and/or attempts?	☐ **Yes** ☐ **No**
Has there been a suicide attempt within 7 days of this referral?	☐ **Yes** ☐ **No**
Are there any concerns regarding addiction that the applicant would like to address?	☐ **Yes** ☐ **No**
Are there any concerns regarding violent or aggressive behaviours that we need to be aware of?	☐ **Yes** ☐ **No**
Please provide details:	
Does the applicant have any criminal convictions or pending cases that may impact on access to services?	☐ **Yes** ☐ **No**
If **Yes**, please provide details:	

CUSTOMER CONSENT

Referrer is required to obtain the Applicants consent to make this referral.

I_____ (insert name) have requested support to access psychosocial support with Chorus 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 contact the referrer.

Customer signature_____ Date _____

DETAILS OF REFERRING AGENCY

Contact Person		Role	
Agency Name		Email	
Signature		Date Referred	

Thank you for your referral please forward/send to: accessenablersteam@chorus.org.au