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				
Health Care Card	☐ Yes ☐ No ☐ Not known				
Marital Status	☐ Never married ☐ Widowed ☐ Divorced ☐ Separated ☐ Married / De facto ☐ Not stated/inadequately described				
Emergency Contact					

All sections must be completed

Current NDIS Status: please circle **Yes/No** below as applicable **(NDIS participants are not eligible for this program)**

- Has the Applicant previously tested their NDIS eligibility ☐ **Yes** ☐ **No**
- Did the Applicant receive assistance to submit previously ☐ **Yes** ☐ **No**
- Does the Applicant require assistance to submit/re-submit NDIS Application ☐ **Yes** ☐ **No**

Does the applicant have severe episodic mental illness with associated impact on psychosocial functioning? ☐ **Yes** ☐ **No**
(Psychosocial functioning refers to a **person's ability to perform the activities of daily living** and to engage in meaningful relationships with other people in ways that are gratifying to them and others, and that meets the demands of the community in which the individual lives).

Would the Applicant benefit from the CPS Program – Short-Term, 12-week, goal-based, 1:1 support, or group support?

☐ Yes ☐ No

What short-term goal would the Applicant like to work on?

Please indicate the current level of distress experienced by the applicants. Please circle: ☐ **High** ☐ **Medium** ☐ **Low**

Please share any additional relevant information:
Current Accommodation status: please circle **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?	
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:	

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

BRIEF RISK ASSESSMENT

Surname		First Names(s)	
Patients Address		Post Code:	
UMRN		Birth Date		Gender	☐ Male ☐ Female ☐ Other:

SOURCE OF INFORMATION

☐ The consumer ☐ Immediate carer (parent, spouse, child)
☐ Other informants (family, friends) ☐ Previous clinical records
☐ Assessing clinician's knowledge of consumer's past behaviour/current clinical presentation
☐ Police/ambulance/other agencies
☐ Other (please specify) _____

SUICIDALITY

Static (historical) factors	Yes (1)	No (0)	Not Known	**Dynamic (current) risk factor**	Yes (2)	No (0)	Not Known
Previous attempt(s) on own life	☐	☐	☐	Expressing suicidal ideas	☐	☐	☐
Previous serious attempt	☐	☐	☐	Has plan/intent	☐	☐	☐
Family history of suicide	☐	☐	☐	Expresses high level of distress	☐	☐	☐
Major psychiatric diagnosis	☐	☐	☐	Hopelessness/perceived loss of coping or control over life	☐	☐	☐
Major physical disability/illness	☐	☐	☐	Recent significant life event	☐	☐	☐
Separated/Widowed/Divorced	☐	☐	☐	Reduced ability to control self	☐	☐	☐
Loss of job/retired	☐	☐	☐	Current misuse of drugs/alcohol	☐	☐	☐

PROTECTIVE FACTORS *(describe):*

LEVEL OF SUICIDE RISK (total score):	☐ **LOW (<7)**	☐ **MODERATE (7-14)**	☐ **HIGH (>14)**

AGGRESSION/VIOLENCE

Static (historical) factors	Yes (1)	No (0)	Not Known	**Dynamic (current) risk factor**	Yes (2)	No (0)	Not Known
Recent incidents of violence	☐	☐	☐	Expressing intent to harm others	☐	☐	☐
Previous use of weapons	☐	☐	☐	Access to available means	☐	☐	☐
Male	☐	☐	☐	Paranoid ideation about others	☐	☐	☐
Under 35 years old	☐	☐	☐	Violent command hallucinations	☐	☐	☐

Criminal history	☐	☐	☐	Anger, frustration or agitation	☐	☐	☐
Previous dangerous acts	☐	☐	☐	Preoccupation with violent ideas	☐	☐	☐
Childhood abuse	☐	☐	☐	Inappropriate sexual behaviour	☐	☐	☐
Role instability	☐	☐	☐	Reduced ability to control self	☐	☐	☐
History of drug/alcohol misuse	☐	☐	☐	Current misuse of drugs/alcohol	☐	☐	☐

PROTECTIVE FACTORS *(describe):*

LEVEL OF VIOLENCE RISK (*total score***):**	☐ **LOW (<7)**	☐ **MODERATE (7-14)**	☐ **HIGH (>14)**

OTHER RISKS IDENTIFIED (AND RISK FACTORS)

RISK MANAGEMENT ISSUES (*please ensure alerts are noted here***)**

TO BE COMPLETED BY ASSESSING CLINICIAN			
Full Name		Designation	
Agency Name		Date	
Signature			

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

This Brief Risk Assessment was obtained from the Healthy WA Website

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