|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Referral** |   | / |  | / |  |   |  |  |  |
|  |
| **Applicant Details** |
| First Name: |  | Last Name: |  | DOB: |  | / |  | / |  |
| Sex: | M |[ ]  F | [ ]   |  Other |[ ]  Please specify:  |  |
| Cultural Requirements: |  |
| Address: |  |
| Phone / Mobile: |  | Best Contact Time: |  |
| Mental Health Illness: |  | Diagnosed: | Y |[ ]  N |[ ]   |
|  |  |  |  |  |  |
| **CPS Eligibility: Must answer YES to all** |  |  |  |  |  |
| Participant consents to informal and/or structured, socially based capacity building activities and/or individual, one-on-one Peer Worker support to work toward psychosocial recovery-focused goals | Y |[ ]  N |[ ]   |
| Participant does not require long term, intensive individualised support | Y |[ ]  N |[ ]   |
| Participant is 16 years or over | Y |[ ]  N |[ ]   |
| Does not receive NDIS funding | Y |[ ]  N |[ ]   |
| Participant currently receiving treatment from their GP (mental health care plan) | Y |[ ]  N |[ ]   |
| **Reason for Referral** *(Please tick relevant boxes to demonstrate needs of client)* |
| Mental Health Capacity Building Support |[ ]  One-On-One Goal-Specific Recovery Focused Support  |[ ]  Housing / Tenancy Education  |[ ]
| Community Engagement |[ ]  Social Isolation / Network Building  |[ ]  Service linkages and referrals  |[ ]
| Informal group activities |[ ]  Goal Setting / Motivation |[ ]  Cultural / spiritual  |[ ]
| Structured group activities |[ ]  Self-care |[ ]  Vocational skills and goals |[ ]
| Facilitation of links with other community services, psychologists and/or psychiatrists |[ ]   |
| *(Please provide details below)* |
|  |
|  |
| **Existing Agencies / Individuals involved or working with applicant** (eg*. GP, Psychologist, Job Network, Youth Justice, support services etc.)* |
| Name: | Name: |
|  |  |
| Relationship/Service: | Relationship/Service: |
|  |  |
| Contact Details: | Contact Details: |
|  |  |
| Name: | Name: |
|  |  |
| Relationship/Service: | Relationship/Service: |
|   |  |
| Contact Details: | Contact Details: |
|  |  |

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| --- |
| **Risk Factors** (Safety concerns to self and others: *Aggressive/violent behaviours, drug & alcohol abuse, suicide attempts/ideation, legal matters etc.)* |
|  |

|  |
| --- |
| **Referrer Details** |
| Name: |  | Relationship: |  |
| Agency / Organisation:  |  |
| Address: |  |
| Phone: |  | Mobile: |  | Fax: |  |
|  |
| **Consent to contact other Agencies / Persons** |
| ***CPSB001.01 Consent to Obtain and Release Information*** must be completed alongside this referral form. |
| **Applicant’s signature (please state if verbal consent received):** |  |
|  |

**Email referral to** **cps@impact.org.au** **with the word REFERRAL in the subject line**