Richmond Fellowship Queensland

Commonwealth Psychosocial Support (CPS)

Program Referral Form

Please return the completed form to:

Email:

maryborough@rfq.com.au

bundaberg@rfq.com.au

For further information, please call:

(07) 3363 2533

Who We Are

Richmond Fellowship Qld (RFQ) is not for profit community-owned organisation that supports people facing mental health challenges and social disadvantage by providing leading recovery-oriented psychosocial services.

Purpose of the Program	Program Eligibility
The CPS service will assist participants for improved mental health and wellbeing, and serves to complement Queensland Health in psychosocial support for those ineligible for NDIS.	To be eligible for support the person must: • be aged over 16 years • be living with a moderate to severe mental illness and have reduced psychosocial functioning • not be assisted by the NDIS or Continuity of Support arrangements • not be a client of a mental health program funded by Queensland Health

Confidentiality

RFQ values people's privacy and right to confidentiality and has quality control procedures to ensure the information provided is safeguarded. RFQ adheres to the Australian Privacy Principles (APP's) set out in the Privacy Act 1988, amended by the Privacy Amendment (Enhancing Privacy Protection) Act 2012 through the RFQ Privacy Policy and the RFQ Privacy Collection Statement.

Sending a Referral Form

Please send completed form, marked confidential to maryborough@rfq.com.au or bundaberg@rfq.com.au
(email is RFQ's preferred method of referral).

Referrer Information and Signature

Name of Referrer		Organisation	
Position		Email	
Office address		Phone	

By signing this form:

I confirm that the client (or if applicable, their interpreter or decision maker), are in agreement with their referral to this program, and have consented to the information in this referral form being provided to RFQ.

Referrer Signature: _____ Date: / /

Please attach further information to inform our assessment and support.

This service is supported by funding from Central Qld, Wide Bay, Sunshine Coast PHN under the Australian Government's PHN Program.

Personal Details of Participant			
Surname		Given names	
Date of birth		Gender	
Address		Phone	
Email			

Cultural Needs of Indigenous Australians

Does the client identify as:

☐ Aboriginal but not Torres Strait Islander origin ☐ Torres Strait Islander but not Aboriginal origin

☐ Both Aboriginal and Torres Strait Islander origin ☐ Neither Aboriginal nor Torres Strait Islander origin

☐ Other, please specify:

Cultural and Linguistic Diversity		
Country of Birth	**Year of first arriving in Australia**	**Main Language Spoken**
Interpreter required?	☐ Yes ☐ No	

Decision Making

Please identify if the participant has an administrator appointed for decision making? If yes, please identify who has been appointed for each matter:

The Adult Guardian	No ☐ Yes ☐	
Power Of Attorney	No ☐ Yes ☐	
Advanced Health Directive	No ☐ Yes ☐	
The Public Trustee	No ☐ Yes ☐	
Enduring Power of Attorney	No ☐ Yes ☐	
Other	No ☐ Yes ☐	

Next of Kin (NOK)		**GP Contact Details**	
Name		Name	
Relationship		Email	
Address		Clinic address	
Phone number		Phone number	
☐ Contact in case of emergency		We routinely liaise with and send correspondence to GP's at the beginning and end of treatment. Please tick this if you do NOT wish for this to occur ☐	

Clinical Information			
Brief reason for referral:			
Please provide details of the person's diagnosed mental illness, OR the early symptoms of mental illness they are experiencing:			
Please list the person's current prescribed medication (attach as required):			
Are there any side effects we need to be aware of?	No ☐ Yes ☐	Details:	
Please provide any information regarding the person's mental health or physical health history that may inform our services for the person (attach as required):	No ☐ Yes ☐	Details:	
Are there any current alerts for this person? For example: health alerts, risks, orders, etc – please list. If so, please provide details of risk management in relation to the alerts (attach as required):	No ☐ Yes ☐	Details:	
Is the person at risk of self-harm, suicide or harm to others?	No ☐ Yes ☐	Details:	
Are there any other health needs that we need to be aware of?	No ☐ Yes ☐	Details:	
Are there any other agencies currently involved in the clients care? (i.e. Government, Non-Government, GP, psychiatrist, Probation & Parole, Child Safety)	No ☐ Yes ☒	Details:	