Referral Form

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Murgon QLD 4605
Phone: (07) **0458 077 152 OR 1800 179 233**
Fax: (07) 4168 2444
E-MAIL: camerond@sbctc.com.au
Web: www.impact.org.au

Personal Helpers & Mentors Program

DATE OF REFERRAL **...../...../.....**

APPLICANT DETAILS

Name:	Gender: M F	D.O.B:
Ethnicity:	NESB Y N	Language:
Address:		
Phone Number:	Mobile Number:	Best Contact time:
Caregiver/parents details (if applicable) :		
Has the PHaMs program been explained to applicant?	Y	N
Does the applicant agree to participate in the PHaMs Program?	Y	N
Mental Health Illness:	Diagnosed: Y	N

REASON FOR REFERRAL ***(SEVERELY LIMITED FUNCTIONING IN; PERSONAL CAPACITY ACTIVITIES, COMMUNITY PARTIPATION ACTIVITIES AND INDEPENDENT LIVING ACTIVITIES)*** *Please attach any additional information)*

RISK FACTORS ***(SAFETY CONCERNS TO SELF & OTHERS; AGGRESSIVE/VIOLENTBEHAVIOURS, DRUG & ALCOHOL ABUSE, SUICIDE ATTEMPTS/IDEATION, LEGAL MATTERS.....)***

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EXISTING AGENCIES/INDIVIDUALS INVOLVED /WORKING WITH APPLICANT (eg; GP, Psychologist, Job Network, Youth Justice, Support services…..)	
Name:	Name:
Relationship/Service:	Relationship/Service:
Contact Details:	Contact Details:
Name:	Name:
Relationship/Service:	Relationship/Service:
Contact Details:	Contact Details:

REFERRER DETAILS

Name: Relationship:

Agency/Organisation:

Address:

Phone: Mobile: Fax:

CONSENT TO CONTACT OTHER AGENCIES/PERSONS

Does the applicant give consent for the Referrer and above listed agencies/persons to be contacted to acquire additional information to assist in the referral process?

N **Y** (if yes) Applicant's signature _____

(PHaMs Program use only)

Referral accepted Yes No

If No – provide details: .....

.....

If Yes Assigned PHaMs Worker .....

Date Processed ..... by PHaMs Team Leader .....