Partners in Recovery (PIR) Referral Tool

Referrer to complete this tool to identify the person's initial need(s) and record appropriate details for referrals(s).

Date: _____

1. REFERRER DETAILS

Referrer name: _____ Surname: _____

Service: _____

Suburb: _____ Postcode: _____

Phone: _____ Email: _____

2. CLIENT DETAILS

First Name: _____ Surname: _____

DOB: _____ Gender: _____ Phone: _____

Address: _____

Suburb: _____ Postcode: _____

Identifies as: ☐ Aboriginal ☐ Torres Strait Islander background ☐ Culturally and Linguistically Diverse Background

Country of Birth: _____ Interpreter Required (Language/Auslan): _____

Employment Status: ◯ Full Time ◯ Part Time ◯ Casual ◯ Not Employed ◯ Other

NDIS package approved: ☐ Yes (Client is not eligible for PIR service if receiving NDIS package)
☐ No Comments: _____

3. EMERGENCY /FAMILY MEMBER / NOK CONTACT

If the client is a child, please provide the details of the parent or guardian who is responsible for decisions about treatment.

First Name: _____ Surname: _____

Phone: _____ Relationship to Client: _____

Permission to contact: ☐ Yes ☐ No

4. MENTAL HEALTH AND OTHER NEEDS

Mental Health Diagnosis (if known):
Has the person received previous mental health care? ☐ **Yes , please state:** ☐ **No**
Presenting issues and history:
What services/supports are currently involved?
Purpose of referral to PIR:

Fax this referral to 8677 9510 along with any supporting assessments or documents.

Area of Need: Please tick appropriate boxes where person needs support in other areas.

☐ Alcohol/Drugs	☐ Family	☐ Legal	☐ Transport
☐ Culture	☐ Finance	☐ Physical health	☐ Other
☐ Disability	☐ Gambling	☐ Self-Care	
☐ Education	☐ Gender	☐ Sexuality	
☐ Employment	☐ Housing	☐ Social/Community	

Please provide details about the area of need.

RISK ASSESSMENT (MUST BE COMPLETED)

If your client is presenting in an acute psychiatric crisis or risk is high, please call your local area mental health service

Current Suicidal Thoughts: ◯ **No** ◯ **Yes** : _____

Current Suicidal Plan: ◯ **No** ◯ **Yes** : _____

Current Suicidal Intent: ◯ **No** ◯ **Yes** : _____

Recent Suicide attempt in the last three months? ☐ **Yes** ☐ **No**

Relevant History: _____

Suicide Risk Level: ◯ **Not Apparent** ◯ **Low** ◯ **Medium** ◯ **High**

Current Self Harm Thoughts: ◯ **No** ◯ **Yes** : _____

Current Self Harm Plan: ◯ **No** ◯ **Yes** : _____

Current Self Harm Intent: ◯ **No** ◯ **Yes** : _____

Current behaviours: _____

Relevant History: _____

Self-Harm Risk Level: ◯ **Not Apparent** ◯ **Low** ◯ **Medium** ◯ **High**

Current Harm to Others Thoughts: ◯ **No** ◯ **Yes** : _____

Current Harm to Others Plan: ◯ **No** ◯ **Yes** : _____

Current Harm to Others Intent: ◯ **No** ◯ **Yes** : _____

Relevant History: _____

Risk to others: ◯ **Not Apparent** ◯ **Low** ◯ **Medium** ◯ **High**

Other Risks /Vulnerabilities:

CURRENT RISK MANAGEMENT PLAN

◯ **Yes,** date of plan: _____ Completed By: _____

◯ **No,** preparation of plan will be completed on _____ By: _____

◯ **N/A** Please comment: _____

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5. CONSENT

☐ Client / parent / guardian consents to Eastern Melbourne PHN (EMPHN) to seek, collect and share their relevant health information to the appropriate service provider(s) for the purpose of referral for ongoing care.

☐ Client / parent / guardian consents to their/ their child's de-identified information being used by EMPHN for evaluation and reporting purposes to the Department of Health. They understand this data, which does not include their name, address or Medicare number, but will include information such as date of birth, gender and types of services they use, will be used for the purposes of improving health services in Australia. Client understands that their/ their child's information will not be provided to the Department of Health if they indicate they do not consent.

By proceeding with this referral, please be aware that you are agreeing that your identified information may be provided to the National Disability Insurance Scheme (NDIS). Partners in Recovery is currently supporting the transition to the NDIS and all participants in the PIR program are being supported to apply for the NDIS. The National Disability Insurance Agency (NDIA) may periodically seek contact details and service data related to all people currently and previously registered in the PIR program. (The NDIA has the authority to collect this information under the National Disability Insurance Scheme Act 2013 (NDIS Act).

Please list all health professionals involved in client's care and client/parent/guardian consent for EMPHN to contact them for the purposes of seeking collateral information: e.g. psychiatrist, GP, CAT team, allied health professionals etc.

Care Team	Name	Organisation	Contact details	Client consent to contact?
other			Phone Fax:	Yes ◯ No ◯
other			Phone: Fax:	Yes ◯ No ◯
other			Phone: Fax:	Yes ◯ No ◯
other			Phone: Fax:	Yes ◯ No ◯

Client Signature: ..... ☐ Or verbal consent received **Date:** ..../..../.....

Referrer Signature: ..... **Date:** ..../..../.....

Further information: _____

_____

_____

_____

_____

Fax this referral to 8677 9510 along with any supporting assessments or documents.