Partners in Recovery (PIR) Referral Tool

phn EASTERN MELBOURNE
An Australian Government Initiative

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

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: ____________________

Further information:____________________

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5. CONSENT

Consent to participate:
Eastern Melbourne PHN (EMPHN) and providers who run services that EMPHN funds are required to collect and use information about you. This includes personal information, and information about the services you are receiving. This information is used by staff members involved in delivering services to you, and by staff at EMPHN. This information is used and shared to ensure you get the right service for your needs, to monitor service delivery and performance, and evaluate and make improvements to services. This consent condition is mandatory – to receive services, you must agree.

I/ parent/guardian consents to receive services and for the collection and use of information about me and the services I receive, as outlined above. ☐ Yes ☐ No

EMPHN funded services are evaluated to ensure they are meeting the needs of consumers and our community. You may be contacted to participate in additional evaluation activities associated with your care. If contacted, you can choose whether you wish to take part or not.

Consent to collect and share information with other services:
I/ parent/ guardian consents to the collection and sharing of all relevant information with other service providers relevant to assist my/ my child's overall care. I understand that my information will not be shared if I do not consent.
Yes No

If YES, please list all service providers you consent to being contacted by EMPHN or EMPHN's funded service provider and discussing your/ your child's care (e.g. GP, psychiatrist, CAT team, allied health professionals, etc.)

Care Team	Name	Organisation	Contact details
			Phone: Fax:
			Phone: Fax:
			Phone: Fax:

Consent to share anonymised data with the Department of Health:
As the overall funder, the Department of Health is interested in anonymised data which will be used for evaluation purposes to improve mental health services in Australia. This anonymised data includes information about you, such as your gender, date of birth and types of services received, but **does not** include any information that could identify you (e.g. your name, address or Medicare number).

I/ parent/ guardian consents to EMPHN providing anonymised data about me and the services I receive to the Department of Health. I understand that my information will not be shared if I do not consent.
Yes No

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).

Consumer signature: ....**Date**: ..../......./.......

Verbal consent provided by consumer **Referrer signature**: ....**Date:** ..../......./.......

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