Psychosocial Support Referral Form

Information collected on this referral form will determine program eligibility.

APPLICANT DETAILS					
Name			Contact Number		
Address				Post Code:	
Email					
Date of Birth		Age in Years		Gender	☐ Male ☐ Female ☐ Other:
Cultural Identity	☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐Neither				
Country of Birth			Main Language Spoken		
Residency Status	Australian Citizen **Yes/No**				

All sections must be completed:
Is the applicant aged over 18 and under 65? **Yes/No**
Has the applicant agreed to this referral? **Yes/No** (Please ensure that the applicant signs the consent section of this referral found on page 3)
Current NDIS Status: please circle **Yes/No** below as applicable **(NDIS participants are not eligible for this program)**
• Has the Applicant previously tested their NDIS eligibility **Yes/No** • Does the Applicant require assistance to submit/re-submit NDIS Application **Yes/No**
Does the applicant have severe episodic mental illness with associated impact on psychosocial functioning? **Yes/No** (Psychosocial functioning reflects a **person's ability to perform the activities of daily living** and to engage in relationships with other people in ways that are gratifying to them and others, and that meets the demands of the community in which the individual lives)
Would the applicant benefit from time limited psychosocial support? **Yes/No**
What is the applicants' current level of distress? Please circle: **High** **Medium** **Low**
Please share any additional relevant information:
Current Accommodation status: please circle **Yes/No** below as applicable
• Does the applicant have stable accommodation? **Yes/No** • If **No,** is the applicant engaged with accommodation services? **Yes/No** • If **Yes,** please provide further details of current engagement and services being accessed:

Is the applicant currently engaged with **Community Mental Health Services**? **Yes/No** If **Yes**, please provide details & duration of engagement:
Is the applicant currently engaged with **other Psychological Services**? **Yes/No** If **Yes**, please provide details & duration of engagement:
Is the Applicant currently receiving support from any other services? **Yes/No** If **Yes**, please provide details:

ADDITIONAL REFERRAL INFORMATION			
Has the applicant ever been diagnosed with a mental illness?			☐ Yes ☐ No
Diagnosis		Who provided diagnosis?	When?
Primary Diagnosis			
Additional Diagnosis			
If **No**, what mental health concerns prompted this referral for psychosocial support?			
What psychosocial supports are required?			
Does the applicant have any medical conditions or disabilities?			☐ Yes ☐ No
If **Yes**, please provide details:			

Does the applicant have any current Alcohol and/or Other Drug (AOD) issues? ☐ Yes ☐ No
If **Yes,** please provide details of issues and of the AOD supports that the applicant is currently engaged with:
Does the applicant have any Cultural considerations with regards to receiving services? ☐ Yes ☐ No
If **Yes,** please provide relevant details:

RISK BEHAVIOURS *Please note: the identification of any risk behaviours does **not** automatically exclude the person's ability to be referred*	
Does the applicant have a history of self-harm?	☐ Yes ☐ No
Does the applicant have a history of suicidal ideation and/or attempts?	☐ Yes ☐ No
Has there been a suicide attempt within 7 days of this referral? If yes, please attach a current safety plan.	☐ Yes ☐ No
Are there any concerns regarding addiction that the applicant would like to address?	☐ Yes ☐ No
Please provide details:	
Are there any concerns regarding violent or aggressive behaviours that we need to be aware of?	☐ Yes ☐ No
Please provide details:	
Does the applicant have any criminal convictions or pending cases that may impact on access to services?	☐ Yes ☐ No
Please provide details:	

CUSTOMER CONSENT

Referrer is required to obtain the Applicants consent to make this referral.

I_____ have requested support to access psychosocial support with Chorus and give my consent for this referral to be given to the Chorus and all information in this referral is true and correct.

I do/do not (please circle appropriate one) give consent for Chorus staff to contact the referrer.

Customer signature_____ Date _____

DETAILS OF REFERRING AGENCY			
Contact Person		Role	
Agency Name		Email	
Agency Address			
Phone No.		Fax No.	
Signature		Date Referred	

Thank you for your referral please forward/send to:

ALBANY
hello@chorus.org.au
122 Grey Street,
Albany, WA 6330

BUNBURY
hello@chorus.org.au
Unit 1/82 Blair Street
Bunbury WA 6230

MANDURAH
hello@chorus.org.au
60/98 Mandurah Terrace
Mandurah WA 6210

Date received _____ By: _____ Signature _____