

# REFERRAL FORM

**Partners in Recovery (PIR) provides assistance to adults with severe and persistent mental illness who have complex needs that require support from multiple agencies.**

PIR aims to ensure services and supports from multiple sectors work in a more collaborative, coordinated, and integrated way.

As the National Disability Insurance Scheme (NDIS) rolls out nationally, the Partners in Recovery program will continue to ensure continuity of support to participants and assist in transitioning to this new service.

## ELIGIBILITY CHECKLIST Are you, or is the person you are referring:

25 years or over?  Y  N  Unknown

Experiencing a severe mental health issue that has significantly impacted on health and wellbeing for over one year? Please provide details:  Y  N  Unknown

Requiring support from multiple agencies and have complex needs? Please provide details:  Y  N  Unknown

Requiring substantial support and assistance to engage with various services to meet needs?  Y  N  Unknown

Requiring service coordination arrangements?  Y  N  Unknown

## CONSENT

Is the person referred consenting to be involved in the PIR program?  Y  N

Is the person referred consenting to share the above information with a PIR Support Facilitator for follow up?  Y  N

## PARTICIPANT DETAILS

Referral date:

**Name:**  **D.O.B.**  or estimated age: .....

**Phone:**  **Email:**

**Gender:**  Male  Female  Intersex  Trans  
 Non-binary  Other .....

**How would you like to be contacted?**  
 Phone  Email  Post  SMS

**Alternative contact (name/phone/email):**

**Do you identify with any of the following:**

Aboriginal  Torres Strait Islander

Both Aboriginal and Torres Strait Islander

Neither Aboriginal or Torres Strait Islander

Not stated

Culturally or linguistically diverse

Country of birth .....

**Do you identify with any of the following:**

Lesbian  Gay  Bisexual

Queer  Not stated  Heterosexual

Asexual  Pansexual

Other .....

## ACCOMMODATION

**Length of time at current accommodation:**  
Years ..... Months: .....

**Is an interpreter required?**  Yes  No

**Address:** (if no fixed address please provide a place of contact):  
.....  
.....

Language .....

## SOURCE OF INCOME

- Disability Support Pension     Other pension or benefit (not super)     Paid employment  
 Compensation payment     Other (super, investments etc)     Nil income  
 Not known     Not stated or inadequately described

## REFERRER DETAILS (Please provide ALL details)

Source of referral:  Self     Family member / Friend / Carer     Service provider     Unknown / not stated  
 Other (specify): .....

Referrer name:	Phone:
Organisation:	Fax:
Relationship at time of referral:	Will this relationship continue? <input type="checkbox"/> Y <input type="checkbox"/> N
Email:	

## MENTAL HEALTH (Please provide ALL details)

Has there been a mental illness diagnosis?:     Y     N **(Please attach supporting documentation if available)**  
If yes, details of diagnosis:

Have you ever been hospitalised for a mental health condition?     Y     N  
If so, when was the last date of hospital admission: ..... **(Please attach supporting documentation if available)**

## NDIS ELIGIBILITY

Is the person accessing support under the National Disability Insurance Scheme (NDIS)?     Y     N     Unknown

## SERVICES AND SUPPORTS

What assistance are you seeking from Partners in Recovery in supporting your mental health?

Are there any safety concerns or other issues we may need to be aware of?

### Office use only

PIR ID key: ..... Referral to organisation date: .....

Partner organisation: .....

**Please fax completed Referral Form to: 07 3864 7546**

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