

Referral Form



Personal Details	
Name:	
Current residence	
Contact Number	
Date of Birth	
Gender	
Is the participant of Aboriginal or Torres Strait Islander origin?	
Is the participant of Culturally and Linguistically Diverse (CALD) background?	

NDIS Information	
Has NDIS paperwork been submitted? If yes, SIL Quote required in the plan?	
NDIS No	
Plan Managed / Agency Managed? Please provide details	
Plan Manager Details- name and Email:	
Copy of NIDS Plan provided Yes/ No	

Psychiatric Diagnosis

Physical illnesses / Communicable Diseases: e.g. Hep B, HIV, TB, STD and etc.

Medications	
List of medications	
Current medication setup (independent/ Webster pack, administered by staff when)	
Adherence issues	
Allergies	

GP Details

Current GP	
GP Contact details	

Details of Mental Health Treating Team	
Psychiatrist	
Clinical Manager	
Is the participant under a PTO?	
Is the participant under any other orders?	

Guardians and carers Details	
Does the participant have a guardian? If yes, please provide details	
Does the participant have a nominated carer?	
Does the participant have a nominated carer? If yes, please provide details	
Family members / NOK Contact details:	

MENTAL HEALTH	
How does the participant present when unwell?	
Any known triggers/ high risk situations?	
What are their early warning signs?	
What supports/ strategies does the participant require when unwell?	

Risk of suicide	
Past suicide attempts	
Protective Factors	
De-escalation strategies	

Risk of self-harm	
Frequency	
Method	
Severity	

Protective factors	
De-escalation strategies	

PERSONALITY / BEHAVIOUR	
Does the participant get along with others easily?	
Current or history of aggressive /challenging behaviours.	
Strategies for managing aggressive/ challenging behaviours?	

OTHER COMMENTS

Referrer's Name:

Referrer's signature:

Contact email and phone number:

Date:

Participant / Guardian Signature:

Consent form signed- Yes/No: