Central Coast NSW Partners in Recovery Organisation

CENTRAL COAST PRIMARY CARE

Central Coast Partners In Recovery Referral

Please read all available information including the inclusion criteria before completing this form. Inclusion criteria: each of the following five (5) criteria must be met in order to be eligible for the Partners In Recovery program (PIR)

1. The person has a mental illness that is severe in degree and persistent in duration
2. The person has complex needs which significantly impact on their day to day functioning and quality of life and will benefit from assistance from multiple agencies
3. The person requires substantial support and assistance to engage with the various agencies to meet their needs
4. There are no existing care coordination arrangements in place to assist the person is accessing the necessary services or, where they are in place, those arrangements have not met the person's needs and are likely to be addressed by acceptance in to PIR
5. The person or their legal guardian has indicated their consent to being involved and indicated a willingness to participate in PIR

Important: Fields marked with a * are required to be completed in order for the referral to be processed.

Referred Person's Information Details

Name*	Phone and email	Address Mail Address	Date of Birth* Estimated DOB ☐
Sex*	**Culture**	**Country of birth**	**First Language**
☐ Male ☐ Female ☐ Other ☐ Intersex			
Level of English	☐ Very Well ☐ Well ☐ Not Well ☐ Not at all ☐ Unknown		
Is the person from CALD background? *	☐ Yes ☐ No ☐ Unknown	**Does the person require an interpreter?**	☐ Yes ☐ No ☐ Unknown
☐ The person is of Aboriginal but not Torres Strait Islander origin		☐ The person is of both Aboriginal & Torres Strait Islander origin	
☐ The person is of Torres Strait Islander but not Aboriginal origin		☐ The person is neither Aboriginal or Torres Strait Islander origin	
☐ Origin not stated or inadequately described			

Financial/ Education

Source of income	☐ Full Time work ☐ Disability Support Pension ☐ Compensation payments ☐ Part Time work ☐ Other Pension or benefit ☐ Other ☐ Nil income		
Employment Status	☐ Full Time ☐ Part Time ☐ Unemployed ☐ Not in the labour force		
Is the person under Guardianship?	☐ Yes ☐ No ☐ Unknown	**Is the person currently under Financial Management Services?**	☐ Yes ☐ No ☐ Unknown
Education – Highest level	Detail:		
Current Education participation	☐ TAFE ☐ Secondary School ☐ University ☐ Other:		

Living Arrangements

Marital Status	☐ Married (registered & de facto) ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married		
Type of accommodation*		**How long has the person lived in this accommodation:**	
Is this accommodation stable:	☐ Yes ☐ No ☐ Unknown	**Does the person live with others:**	☐ Yes ☐ No ☐ Unknown Details:
Will anyone else be present When PIR visits the home?	☐ Yes details: ☐ No		
Does the person have a child under 18 in their care?	☐ Full time ☐ Part Time ☐ No ☐ Unknown Please provide details:		
Does the person provide care for any other people?	Details:		
Does the person have a Primary Carer?	☐ Yes details: ☐ No		

Mental Health Status

Mental Health Diagnosis*:		
Diagnosing Health Care Professional / Service:		
Year of Diagnosis or first treatment:		
Is there are formal diagnosis (please attach copy if yes):	☐ Yes ☐ No – if no, what are the main concerns/ needs?	
Does the person have a principal clinical mental health provider *?		☐ Yes ☐ No If yes please specify below
Name:		
Profession:		
Contact details:		
Is the person receiving treatment under a Community Treatment Order?		☐ Yes ☐ No
Is the person at known risk of:	☐ Suicide ☐ Self-harm ☐ Harm to others ☐ Domestic Violence ☐ other:	

Current Supports:		
Agency / Individual:	Type of Service:	Length of time with service or support

Identified Complex needs/ Concerns:

☐ Significant Physical Health concerns Specify:	☐ Acquired Brain Injury	☐ Dementia	☐ Physical Disability Specify:
☐ Intellectual/ Cognitive disability Specify:	☐ Drug & Alcohol Specify:	☐ Speech/ Sensory disability	
☐ Hoarding and squalor	☐ Social Isolation	☐ Homelessness	☐ Family/ relationship break down
☐ Chaotic lifestyle	☐ Poor living skills	☐ History of difficult engagement with services	☐ Involvement in the criminal justice system (past and current)

Main reasons for Referral?* (What are the Current Issues to be addressed)	

National Disability Insurance Scheme (NDIS)

Have you submitted an application for NDIS?	
Do you have an Individual Funded Plan?	YES / NO NDIS Number #
Was your application rejected by NDIS?	Reason:
I have not yet applied for NDIS?	

Referrer's Details

Date of Referral	Name *	Service and Role or Relationship to person referred *	Phone *
Email Address			
Type of service provided*			
What level of service will you continue to provide*			

Thank you for completing the referral form, please submit to

Fax

(02) 4365 6273*

Phone

(02) 4365 2294 , ask for Partners in Recovery Intake Officer

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Additional Information to support the referral:

For Office Use Only

Date Received: _____ Presented to Referral Panel on: _____

Outcome of Referral: Accepted / Declined Initial Assessment Completed on: _____

Initial Assessment Completed by: _____ Assigned to SF: _____ Assigned by: _____