

**One Door Mental Health**

**Frangipani House**

[frangipaniteam@onedoor.org.au](mailto:frangipaniteam@onedoor.org.au)

## SECTION 1: **Details of participant**

|  |  |
| --- | --- |
| **Preferred Title:** 🞏 Mr 🞏 Mrs 🞏 Ms 🞏 Miss | **Surname:** |
| **Preferred Name/s:** | **Given Names:** |
| **NDIS number:**  Do you have a Support Coordinator?  🞏 Yes  🞏 No  If yes, please provide contact details:  Name:  Email:  Phone:  Do you have a Recovery Coach?  🞏 Yes  🞏 No  NDIS Plan  Plan Start Date:  Plan End Date:  Funding Management:  🞏 NDIA Managed 🞏 Plan Managed 🞏 Self-Managed  Funding Management - name and contact details: | **Emergency contact**  Name:  Phone Number:  Secondary Number if possible:  Relationship to Participant: |
| **Street Address:**  Suburb:  Postcode: | |
| **Contact Details:**  Home Phone:  Mobile:  Email address: | **Preferred form of contact:**  🞏 Phone  🞏 Email |
| **Date of Birth:** | **Gender:**  🞏 M (male)  🞏 F (female)  🞏 X (Indeterminate/Intersex/Unspecified  🞏 prefer not to respond |
| **Is the Person from a CALD Background?**  🞏 Yes 🞏 No | **Country of Birth:** |
| **Interpreter Services Required:** 🞏 Yes 🞏 No |
| **Does the person identify Aboriginal and/or Torres Strait Islander?**  🞏 Yes 🞏 No 🞏 Not Known | **Preferred Language:** |
| **Primary Diagnosis:** | |
| **Secondary Diagnosis:** | |
| **Allergies:** | |
| **Allied Health Services**:  🞏 GP  🞏 Psychiatrist  🞏 Psychologist  🞏 Social Worker | |
| **Details of any risks for service delivery:**  🞏 Suicide 🞏 Self-harm 🞏 Alcohol and/or other drugs 🞏 No current identified  🞏 Other (please specify) | |
| **Living Arrangements:**  🞏 Living Alone  🞏 Homeless (rough sleeping, Couch Surfing, Short Term Accommodation)  🞏 Supported Accommodation  🞏 In patient (Hospital)  🞏 other please specify: | |
| **Other services currently being received:** | |
| **Behaviour support plans or current risk assessments + please indicate support needs:** | |

## SECTION 2: **Referral Details**

|  |  |
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| **Referrer:** | **Signature**: |
| **Organisation** (if relevant): | **Position or Relationship:** |
| **Phone:** | **Email** |
| **Reason for referral:**  Individual support  🞏 Yes  🞏 No  Group support  🞏 Yes  🞏 No  Hours of support (please specify):  Days of support (please specify): | |
| **Would you like to add any further information that you feel we should know?** | |

## SECTION 3: **consent**

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| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (being referred) give consent for One Door Mental Health to communicate and collect information from the referrer. I give consent for One Door Mental Health to keep a record of my referral which will remain strictly confidential and only used for its intended purpose. | | |
|  | | |
| **Signature** (Participant) |  | Date: / / 20 |
| Where Verbal Consent is Provided: | |  |
| **Signature** (Referrer) |  | Date: / / 20 |
| **Name** (Witness) |  |  |
| **Signature** (Witness) |  | Date: / / 20 |
|  |  |  |