

**One Door Mental Health**

**Frangipani House**

frangipaniteam@onedoor.org.au

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

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| **Preferred Title:** 🞏 Mr 🞏 Mrs 🞏 Ms 🞏 Miss  | **Surname:**  |
| **Preferred Name/s:** | **Given Names:** |
| **NDIS number:**Do you have a Support Coordinator?🞏 Yes 🞏 NoIf yes, please provide contact details:Name:Email:Phone:Do you have a Recovery Coach?🞏 Yes 🞏 No NDIS PlanPlan Start Date:Plan End Date:Funding Management:🞏 NDIA Managed 🞏 Plan Managed 🞏 Self-ManagedFunding 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 🞏 NoHours 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 |
|  |  |  |