



Referral Process

All sections must be completed and signed by the applicant.

All requested information outlined on Section A must be provided to enable this referral to proceed.

The following will occur once all relevant information has been received:-

- 1) You will be sent a letter within one week confirming we have received your referral.
- 2) This referral will be discussed at the next Intake Meeting. These meetings take place every Wednesday.
- 3) Following the intake meeting, the Intake Worker will contact you and/or the person making the referral to discuss the outcome of your referral and if you have not met the criteria this will be explained to you and/or the person making the referral.
- 4) If your situation alters in any way, please contact the Intake Worker and/or the person making the referral about the progress of the referral.

Centacare Psychiatric Disability Rehabilitation Support Service programs are Voluntary and applicants must be willing to accept support.

Consent for information to be given by the primary clinical mental health provider

I.....give consent for the Centacare

Psychiatric Disability Rehabilitation Support Service to receive the following information from my primary Clinical Mental Health Provider.

- 1. Full mental state assessment. (within a 3 month period)
- 2. Recent discharge summary.
- 3. Clinical Treatment Plan/ Mental Health Plan.
- 4. Detailed Psychiatric Health/Family History.
- 5. Early Warning Signs Management Plan.
- 6. Risk assessment.
- 7. Other as identified:

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This information is provided to Centacare as a mental health service listed in the Victorian Mental Health Act 1986 Division 3, Community Support Services Section 98, funded through the Victorian Department of Human Services Mental Health Branch and will be used by Centacare to process my application.

Centacare PDRS Services are required under Federal and State law to protect the privacy of any person being referred to the service.

Name Date.....
(Print name)

Signature Date.....

Witness Date.....
(Print name)

Signature Date.....

NOTE: SIGNATURES ARE REQUIRED FOR REFERRAL TO PROCEED

APPLICANT'S DETAILS**SECTION B**

Name:

Age: D.O.B.:/...../..... M / F (circle)

Address:

..... Postcode:

Phone: Fax:

Mobile: Email:

CALD required No Yes Indigenous/Torres Strait Islander No YesIs an interpreter required? No Yes Specify language**SERVICE REQUESTED (Please tick the service requested)** **Home based Outreach / Support** (Central Highlands region)
Please complete all sections

Support is provided for people in their own homes who are experiencing a psychiatric illness.

 Respite (Central Highlands region). Please complete sections A, B and D only.

Respite provides short term interventions to either a person experiencing a psychiatric illness and/or their carers in a variety of settings.

Please note: Respite can only be provided for up to 8 days (7 nights).

Please tick service required. Please attach completed registration form for data collection purposes.

Client: Carer: Accommodation: Activity: **M.A.S.C.** (Grampians region). Please complete all sections

Provides residential rehabilitation and outreach service to young adults who experience a mental illness and exhibit high risk behaviours. Primarily aged 16yrs to 24 yrs.

Please tick service required.

Residential Rehabilitation: Outreach Rehabilitation Dual Diagnosis Outreach / Assessment **MOTHERS SUPPORT PROGRAM** (City of Ballarat – LGA)

Provides home based outreach support to women who have dependent children (primarily 0–5 yrs) in their care. The mother must have a diagnosed psychiatric illness and live within the City of Ballarat.

Please tick service required.

Parenting: Living Skills: Social Skills/Recreation: Education/Employment:

SOURCE OF REFERRAL

SECTION C

Please tick referral source.

Self: Carer: Treating Clinician: Support Worker: GP: Case Manager:

Other: please specify.....

Referrer Details:

Name:

Address:

..... **Postcode:**

Phone: **Fax:**

Mobile: **Email:**

PLEASE LIST SUPPORT REQUIREMENTS: eg: shopping, budgeting, social skills,
Not applicable for respite applicants.

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MEDICAL HISTORY

Please list any medical illnesses (past or present) that the program should be aware of ie. hepatitis, epilepsy, diabetes, cardiac condition, allergies, etc.

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RISK ASSESSMENT

Self Harm: Suicidal Ideation

Aggression to others:
Further Detail

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FORENSIC HISTORY (please tick all applicable & provide further information) SECTION D

Damage to property: Court involvement:

Juvenile justice department: Community Based Order:

Protective Service:
Further information

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INCOME DETAILS

Please tick income source.

Centrelink: Wage: Assets (for Office of Housing purposes)

If other please supply details:

PRIVACY

Centacare P.D.R.S. Service is required under Federal and State law to protect the privacy of any person being referred to the service.

Centacare
PDRSS INTAKE
P.O Box 2537
Bakery Hill, 3354

Ph: 5337 8999
Fax: 5332 4465

APPLICANT'S SIGNATURE *(Unsigned referral will not be processed)*

Client Signature: Date:/...../.....

Referrers Signature: Date:/...../.....

Copy given to:

- Consumer:
- Carer:
- Referral source:

Thank you, for your referral.

Please note:

If your referral is unsuccessful you may re-refer after six months.