Aspire
A Pathway to Mental Health Inc.

Referral Form

Person Being Referred **Referral Date:**

Family Name: **Given Name/s:**

Preferred Name: **Gender:** **Date of Birth:**

Is the date of birth estimated? Yes ☐ No ☐ **Marital Status:**

Address:
Town: **Post Code:** **State:**

Contact Phone Number/s

Home: ( ) **Work:** ( ) **Mobile**:
Can we leave a message? Yes☐ No☐
Please circle your preferred method of contact. **Email**:

Dependent Children **:** Yes ☐ No ☐ **Number of Children**:
Lives with Dependent Children: Yes ☐ No ☐

Country of Birth: **Preferred Language**:
Need for Interpreter Services: Yes ☐ No ☐

Indigenous Status: Aboriginal ☐ Torres Strait Islander ☐ Neither ☐
Cultural Background:

Referrer Details

Self Referral :☐
OR
Name of Person Making Referral :
Name of Organisation*:*
Address of Organisation:
Type of Service:
Contact Phone/s No: ( ) Mobile:
Email :
Relationship to the Referred Person:

Psychiatric Diagnosis/s:

General Practitioner Details	**Clinical Support Details**
GP Name:	Name:
Clinic:	Service:
Address:	Address:
Phone No:	Phone No:

CARER INFORMATION: Does the Person have a Carer? Yes ☐ No ☐
Name of Carer:
Carer Relationship:

Reason for Referral:
What are the Rehabilitation and Recovery needs of the referred person? (What things do they want to change?)

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Current Services Record services used in the last three months. Consider all health and community services

Agency	Service Type	Record contact details or other information as appropriate

Risk Factors (issues regarding personal safety or safety to others)

Transport (Does the person have access to transport)

CONSENT TO REFER: Referrals cannot be accepted without consent of the person being referred

To ensure the consumer is able to make an informed decision about consent to the disclosure of their information and agreement to this referral : *(please tick when completed)*

1. Discuss with the consumer the proposed referral to other services/agencies ☐
2. Explain that the consumer's information will only be released to these services if the consumer has agreed ☐
3. Provide the consumer with information about privacy, such as the brochure *'Your Information – It's Private'* ☐
4. Provide the consumer with a copy of this form if requested once completed ☐

Written Consumer Consent **Or**

I have read and understood the information contained in the Referral Form and agree to this referral and information being given to the Rehabilitation and Recovery Services of ASPIRE as identified. My worker/practitioner has discussed with me how and why certain information about me may need to be provided to other service providers. I understand the recommendations and I give my permission for the information to be shared as detailed.

Signed: ____________________

Date: ____________________

Signed by: ☐ Consumer OR ☐ Authorised Representative

Name: ____________________

Witness Signed: ____________________
(Worker/Practitioner)

Witness Name: ____________________

Position: ____________________

Verbal Consent for Consumer

Worker/Practitioner Use Only : Verbal consent should only be used where it is not practicable to obtain written consent.

I have discussed with the consumer, or authorized representative, the information contained in the Referral Form, why certain information about the consumer may need to be provided to other service providers and I am satisfied that the consumer understands the proposed uses and disclosures, and has provided their informed consent to these.

Signed: ____________________
(Worker/Practitioner)

Date: ____________________

Worker/Practitioner Name: ____________________

Position: ____________________

Office use only:
Referral received by: .... Date: / /

Via: Fax Mail Phone Other

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GUIDE FOR REFERRAL

- Does the person have a diagnosed mental illness that has resulted in a psychiatric disability?
- Is the potential service user disadvantaged as a result of mental illness?
- Has the referral been discussed with the individual?
- Has he/she agreed to meet with a rehabilitation team member to discuss their rehabilitation needs?

Please note- self referrals are also welcomed.

To lodge your referral:

Either-

- **Fax -** referral to 03 55 616 193 or
- **Post-** to *Aspire PO Box 683 Warrnambool 3280* in a letter marked 'confidential' or
- **In person-** hand in to your local Aspire office.

Once received this referral will be forwarded to the appropriate Aspire regional office.

1. **Both referrer and referee will be contacted by the agency to further assess eligibility for service**
2. **You can phone any Aspire office on the phone numbers below, if you need further information or assistance to complete this form.**

Please note: Following the initial contact appointment, the person referred is not obliged to use the service.

Aspire office Locations

Warrnambool	Hamilton	Portland	Camperdown
505 Raglan Parade Warrnambool 3280	226 Gray Street Hamilton 3300	12-13/103 Percy St Portland 3305	140 Manifold Place Camperdown 3260
Tel: (03) 5560 3000	Tel:(03) 5571 9980	Tel: (03) 5521 7203	Tel: (03) 5593 1060

Please keep this sheet for reference

Date referral submitted____________________