PARTICIPANT REFERRAL FORM

***Please return completed form to*** ***intake@buttery.org.au*** ***or fax 02) 6687 1039***

**SECTION 1. REFERRAL DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| **Referral date** |  | **Time** |  |
| **Staff member name** |  | **Staff member Phone** |  |
| **Program/service of interest** |  |

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| **Referral organisation details** (*To complete only if referral from another organisation it’s been made.)* |
| **Organisation name** |  |
| **Address** |  |
| **Hours of operation** |  | **Name of program** |  |
| **Contact name** |  |
| **Phone** |  | **Mob:** |  |
| **Participant consent for referral** | **Yes** | **No** |  |
| **Reason for referral** |  |
| **Issues identified by referring agency** |  |
| **Any risks?** | **Self-harm: High Suicidal: High To others: High** | **Medium Medium Medium** | **Low Low Low** |

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| **Referral made by** |
| **Phone Face to face Other (specify):** |

**SECTION 2. PARTICIPANT CONSENT**

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| **Participant consent** |
| I, understand and agree for The Buttery to receive my personal details. I understand my involvement in this process is voluntary and I may withdraw at any time. I also understand that I can withdraw my consent at any time. I give consent to share information relating to my treatment and needs.**Consent type** : Verbal - Date: Time of consent: Written - Time of consent:**Participant signature**: Date: |

**SECTION 3. PARTICIPANT DETAILS**

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| **Participant name** |  | **Reference #** |  |
| **Address** |  | **Date of birth** |  |
| **Phone** |  | **Mobile** |  |
| **Cultural background** |  | **Language spoken** |  |
| **Interpreter required** | **Yes No** | **Gender** | **M F Other** |

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| **Participant emergency contact details** |
| **Full name** |  |
| **Relationship** |  |
| **Address** |  |
| **Phone** |  | **Mobile** |  |
| **Email** |  |
| **Preferred method of contact** | **Mail Phone Mobile Email** |

**SECTION 4. PARTICPANT INFORMATION ON REFERRAL**

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| **Current personal situation** |
| **Summary of services and treatment** |
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| **Client lives** | **Benefits** | **Education** | **Employment** |
| AloneWith family/carer OtherPlease specify: | Yes NoIf so, what type? | School University TAFEOtherPlease specify: | Full-time Part-time CasualSeeking employment |
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| **Family and social support** |
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| **Health issues** |
| **Physical** | **Mental Health** |
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| **Medication** |
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| **Lifestyle activities** |
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| **Legal issues** |
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| **Referral outcome** | **Follow-up actions***(e.g. inform participant with letter)* | **Complete** |
| Organise intake process |  | **Yes** | **No** |
| Provision of service |  | **Yes** | **No** |
| Place on waiting list |  | **Yes** | **No** |
| Referral to another agency |  | **Yes** | **No** |
| Service access decline |  | **Yes** | **No** |
| Other (specify): |  | **Yes** | **No** |

|  |  |
| --- | --- |
| **Date** |  |
| **Staff member name** |  |
| **Staff member signature** |  |

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