



Home Based Outreach Application Form

Name of Person Referred: _____

Date of Referral: / /

The person being referred must meet the following eligibility criteria?

- Experience of *severe & persistent* mental illness that significantly impacts on the ability to live independently and participate in the community. Experience of co-occurring disorders such as drug and alcohol or other, are also eligible
- Aged between 18 and 64 years
- *Live in, or need to move to*, the Eastern Cities of Boroondara, Yarra, Whitehorse, Manningham, or the North Eastern City of Darebin
- Have a *need* to increase living skills
- Have the *desire and are agreeable to actively* participating in the program to *make positive changes*

Name of Person Making Referral: _____

Relationship to the Person Referred: _____

Name of Organisation: *(if applicable)*: _____

Contact Phone No: _____

Email: _____

Source of Referral for the Applicant? *Select one box only.*

- | | |
|---|--|
| <input type="checkbox"/> Self
<input type="checkbox"/> Family member, carer
<input type="checkbox"/> General practitioner
<input type="checkbox"/> Psychiatrist in private practice
<input type="checkbox"/> Psychologist in private practice
<input type="checkbox"/> Specialised mental health care services
<input type="checkbox"/> Alcohol or drug treatment services
<input type="checkbox"/> Hospital | <input type="checkbox"/> Housing/Homelessness support services
<input type="checkbox"/> Disability support services
<input type="checkbox"/> Police, courts or correctional services
<input type="checkbox"/> Centrelink
<input type="checkbox"/> Employment services
<input type="checkbox"/> Personal Support Program
<input type="checkbox"/> Other <i>Please specify</i> |
|---|--|

Office Use Only	
Referral Received by:	Date: / /
by : Phone Fax Mail Other <i>(please circle)</i>	

Consumer Information

To collect common demographic and other essential consumer information that can be shared with another agency.

Consumer details

Family Name: _____

Given Names: _____

Date of Birth: dd/mm/yyyy / /

Sex: _____

Contact Address (for correspondence, home visits etc.)

Postcode

Usual Address (if different from contact address)

Postcode

Contact phone number/s Can leave message?
 (check preferred number)

Home: () Yes No

Work: () Yes No

Mobile: Yes No

Email: Yes No

Country of Birth: _____

Indigenous Status: _____

Need for Interpreter Services: _____

Preferred Language: _____

General Practitioner (if no GP, write NA)

Name: _____

Address: _____

Who the Agency Can Contact if Necessary

(e.g. carer, parent, next of kin, guardian, friend, emergency contact)

Person 1 Name: _____

Contact Address

Phone numbers

Home: _____

Work: _____

Mobile: _____

Relationship to Consumer:

Is this person the consumer's carer? Y / N

Person 2 Name: _____

Address: _____

Phone: _____

Government Pension/Benefit Status: _____

Comments:

Consumer Consent to Share Information

To record freely given informed consumer consent to share their information with a specific agency/is for a specific purpose/s.

Section 1: Proposed Information Uses and Disclosures

The following service(s) are recommended. It is also recommended that relevant information is forwarded to the agency(s) that provide these services, in order that consumers receive the best possible care.

Service Type	Name of Agency	Type of Information <i>(including limits as applicable)</i>
Examples: – Outreach – Physiotherapy	Examples: – ARAFEMI – Nominated clinic	Examples: – All relevant information – Test results only

Section 2: Record of Consumer Consent

2(A) Written Consumer Consent Or

2(a)

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 above.

Signed / Print Name: _____

Date: dd/mm/yyyy / / _____

Signed by: Consumer OR Authorised Representative

Name: _____

Witnessed / Print Name: _____
(Worker/Practitioner)

Worker/Practitioner Name: _____

Position: _____

2(B) Verbal Consent

2(b)

Worker/Practitioner Use Only

Verbal consent should only be used where it is not practicable to obtain written consent.

I have discussed the proposed referrals with the consumer or authorised representative and I am satisfied that the consumer understands the proposed uses and disclosures, and has provided their informed consent to these.

Signed / Print Name: _____
(Worker/Practitioner)

Date: dd/mm/yyyy / / _____

Worker/Practitioner Name: _____

Position: _____

To ensure the consumer is able to make an informed decision about consent to the disclosure of their information, the service provider or referrer should: (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 and advise that the referral for service can still proceed if the consumer does not want information disclosed
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 (see guidelines) once completed

Summary and Referral Information

To record and share a summary of the consumer's problems/issues and an initial action plan when making a referral.

Presenting Issue(s) as Identified by Consumer:

Reason for Referral and Desired Outcome:

Current presentation/episode; presenting problem(s) – observed or described features; screening evidence:

Significant Histories/Recent and past history (medical, functional/daily living skills, social, emotional etc.):

Medications:

Other:

Alerts

Allergies:

Risks:

Additional comments including urgency:

Summary and Referral Information

To record and share a summary of the consumer's problems/issues and an initial action plan when making a referral.

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

Agency	Service Type	Record contact details (name + phone) or other information as appropriate

What is the Consumers' usual accommodation setting? Is that living alone or shared?

If needing accommodation, which area do you have a connection to, and why? See eligibility criteria at beginning of this application

Length of time in current accommodation?

If less than two years, past accommodation types? (e.g. hostel, family home, private rented etc)

Is the Consumer on a current Administration Order?

.....

Does the applicant need assistance with activities or participation in the following life areas?

Tick those applicable

Examples of Support Needs	Clinical View	Consumers' View	Carers View	Details / Comments
Accommodation issues				
Bills, budgeting or debts				
Confidence, motivation, managing symptoms				
Daily living skills i.e shopping, cleaning, self care etc.				
Legal issues				
Establishing or maintaining family & social connections				
Connections to learning or employment opportunities				
Using public transport				
Access psychiatric/clinical services				
Physical health needs				
Community social & recreation activities				
Language/culturally specific services				
Other (please specify)				

Consumer Perspective:

In order for ARAFEMI to prioritise your application and fully appreciate your recovery & rehabilitation needs, can you please complete the following?

- Has the experience of mental illness affected what you can do? Yes ___ No ___
- If Yes, please tell us about the things that you have found difficult since you became ill.

- Is it the mental illness that has held you back from doing the things you would like to do, or is it another reason? _____

- What would you like to change most about your present situation?



5. What have you tried so far to achieve any changes, and how did it go?

6. What helped?

7. What hasn't helped, or has made it made it difficult to make changes?

8. Who has been most helpful and why?

9. Who has been least helpful and why?

10. What do you think the focus of our work with you should be, and what will help you move forward in your recovery?

11. What is the final outcome you desire and how long do you think you will need support to achieve this?

SIGNED: **DATE:** / / 20 ...

Thank you for taking the time to complete this application