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| **Date of Referral** | | | |  | | | | / | |  | | / | |  | | |  | | | | |  | | |  | | | | | | | | | | | | |  | | |
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| **Applicant Details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Name: | |  | | | | | | | | | | Last Name: | | | | |  | | | | | | | DOB: | | | |  | | | | / |  | | / | |  | | | |
| Sex: | M |  | F | | |  | | | Other | | | |  | | Please specify: | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Cultural Requirements: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address: | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Phone / Mobile: | | |  | | | | | | | | | | | | | | | | Best Contact Time: | | | | | | | | | | |  | | | | | | | | | | |
| Mental Health Illness: | | | | |  | | | | | | | | | | | | | | | | Diagnosed: | | | | | | Y | | | |  | | | N | |  | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | |  | |  | | | |  |
| **CPS Eligibility: Must answer YES to all** | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | |  | |  | | | |  |
| Participant consents to informal and/or structured, socially based capacity building activities and/or individual, one-on-one Peer Worker support to work toward psychosocial recovery-focused goals | | | | | | | | | | | | | | | | | | | | | | | | | | Y | | | |  | | | | N | |  | | | |  |
| Participant does not require long term, intensive individualised support | | | | | | | | | | | | | | | | | | | | | | | | | | Y | | | |  | | | | N | |  | | | |  |
| Participant is 16 years or over | | | | | | | | | | | | | | | | | | | | | | | | | | Y | | | |  | | | | N | |  | | | |  |
| Does not receive NDIS funding | | | | | | | | | | | | | | | | | | | | | | | | | | Y | | | |  | | | | N | |  | | | |  |
| Participant currently receiving treatment from their GP (mental health care plan) | | | | | | | | | | | | | | | | | | | | | | | | | | Y | | | |  | | | | N | |  | | | |  |
| **Reason for Referral** *(Please tick relevant boxes to demonstrate needs of client)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mental Health Capacity Building Support | | | | | | | | | | |  | | | | One-On-One Goal-Specific Recovery Focused Support | | | | |  | | | Housing / Tenancy Education | | | | | | | | | | | | | | |  | | |
| Community Engagement | | | | | | | | | | |  | | | | Social Isolation / Network Building | | | | |  | | | Service linkages and referrals | | | | | | | | | | | | | | |  | | |
| Informal group activities | | | | | | | | | | |  | | | | Goal Setting / Motivation | | | | |  | | | Cultural / spiritual | | | | | | | | | | | | | | |  | | |
| Structured group activities | | | | | | | | | | |  | | | | Self-care | | | | |  | | | Vocational skills and goals | | | | | | | | | | | | | | | |  | |
| Facilitation of links with other community services, psychologists and/or psychiatrists | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | | | | | |
| *(Please provide details below)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Existing Agencies / Individuals involved or working with applicant** (eg*. GP, Psychologist, Job Network, Youth Justice, support services etc.)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | | | | | | | | | | | | | | Name: | | | | | | | | | | | | | | | | | | | | | | | | |
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| Contact Details: | | | | | | | | | | | | | | | | Contact Details: | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Risk Factors** (Safety concerns to self and others: *Aggressive/violent behaviours, drug & alcohol abuse, suicide attempts/ideation, legal matters etc.)* |
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| **Referrer Details** | | | | | | | | | | | |
| Name: |  | | | | | | | Relationship: |  | | |
| Agency / Organisation: | | | |  | | | | | | | |
| Address: | | |  | | | | | | | | |
| Phone: | |  | | | | Mobile: |  | | | Fax: |  |
|  | | | | | | | | | | | |
| **Consent to contact other Agencies / Persons** | | | | | | | | | | | |
| ***CPSB001.01 Consent to Obtain and Release Information*** must be completed alongside this referral form. | | | | | | | | | | | |
| **Applicant’s signature (please state if verbal consent received):** | | | | |  | | | | | | |
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**Email referral to** [**cps@impact.org.au**](mailto:cps@impact.org.au) **with the word REFERRAL in the subject line**