Personal Helpers and Mentors Referral

PARTICIPANT DETAILS

Participants name		**Gender**	**DOB:**
Address			
Phone number		**Mobile**	

Reason for referral	**Referral category**	**Please tick box/s**
	Suspected or diagnosed mental health concern; (please circle) Depression Anxiety Post Traumatic Stress Disorder Bi Polar Schizophrenia Personality Disorder Obsessive Compulsive Disorder Schizoaffective Disorder Other please identify_____ Does the person feel that this is stopping them from achieving what they want in life? Yes No	
	Social isolation	
	Addictions *(please identify)* *If client identifies misuse of drugs or alcohol they must be willing to address misuse to be eligible for the program*	
	Suicidal ideation	
	Client request	
	Homeless or risk of homelessness	
	Is there a preference for male or female mentor	M [] F []
	Are you (please circle as many as applicable) Aboriginal Torres Strait Islander Humanitarian Entrant (refugee) Culturally and Linguistically Diverse	
	Language / s spoken:_____	
Any additional important information		
Risk : self or others	Please tick if relevant Low [] medium [] high []	

I give permission for this referral to be given to the Personal Helpers and Mentors program.

I do / do not (please circle appropriate one) give permission for PHaMs program staff to make contact with the referrer and let them know of the outcome of this referral.

PARTICIPANT SIGNATURE:_____ Date:_____

REFERRAL DETAILS

Referred By	Agency	Signature	Date referred
Name: **Phone:**			

SEND DOCUMENT TO:

Attention: **Personal Helpers and Mentors Programme**
Phone: **(08) 9892 6666 or 0447 971 701**
Fax: **(08) 9842 5987**
Email: **nolad@cfi.net.au**
Post: **Unit 2 / 63 Serpentine Rd Albany 6330**

_____
Date received by PHAMP

_____
Signature