PARTNERS IN RECOVERY
REFERRAL FORM

BLACK SWAN HEALTH LTD

Incomplete referral form may result in processing delays and impact on the client's care coordination
Please sign and submit the form to pir@blackswanhealth.com.au or fax to 9201 0033
Please refer to the Black Swan Health website for eligibility and exclusion criteria

Date of referral: __ / ___ / 20___

1. CLIENT DETAILS

Title: _____ ☐ Male ☐ Female ☐ Other D.O.B.: ___ / ____ / _____

Last Name: _____ First name(s): _____

Address*: _____ Suburb: _____ Postcode: _____

** The client's address will determine the appropriate PIR services (PIR North Metro or PIR South Metro) suitable for the client.*
***If the client is required to be seen outside of their allocated area,** please provide the reason below, otherwise leave blank.*

Reason: _____

_____

Mobile: _____ Home: _____ Email: _____

Language spoken at home: _____ Is an interpreter required? ☐ Yes ☐ No

Emergency contact / Next of Kin name: _____ Phone: _____

BINDING MARGIN – NO WRITING

2. REFERRER DETAILS (leave blank if client is referred by GP. Skip to Section3 – GP details)

☐ Tick if Self-referred, and leave this section blank

Referrer name: _____ Position: _____

Organisation / provider name: _____

Address: _____ Suburb: _____ Postcode: _____

Phone: _____ Fax: _____ Email: _____

3. GP DETAILS

GP's name: _____ GP Stamp:

GP's practice: _____

Address: _____

Suburb: _____ Postcode: _____

Phone: _____ Fax: _____ Email: _____

4. REFERRAL INFORMATION

Is the client receiving Disability Support Pension? ☐ Yes * ☐ No

* If Yes, is the client under a public trustee? (Please tick the appropriate box below)

☐ Yes, contact name _____ phone _____ ☐ No

Is the client receiving services from NDIS? ☐ Yes ☐ No

Has the client (or their legal guardian) agreed to be referred to PIR? ☐ Yes ☐ No

Has the client been referred to any other services? ☐ Yes * ☐ No

* If Yes, please list the services: _____

Does the client have a current risk assessment? (please attach if Yes) ☐ Yes ☐ No

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To be eligible for PIR, all of the below criteria MUST be met with description provided

a. The person appears to have, or lives with a diagnosis of, a severe and persistent mental illness.
Referrer notes:

b. The person has multiple unmet needs that may require multiple services from other agencies
Referrer notes:

c. The person requires substantial individual or multi agency support and coordination arrangements are not in place or have failed
Referrer notes:

d. How will the person's needs be addressed by acceptance into PIR
Referrer notes:

BINDING MARGIN – NO WRITING

5. CONSENT TO REFERRAL

Please tick the appropriate boxes below. Partners in Recovery is only able to accept referrals where the client / guardian has consented to the referral, either verbally or in writing.

☐ I consent to be referred to Black Swan Health and give permission for my referrer to be contacted

Client / guardian signature: _____ Date: __ / ___ / 20____

Print Name: _____

☐ I confirm my client has been assessed and meets the eligibility criteria for a referral to Black Swan Health

☐ I have obtained verbal consent from the client / legal guardian to refer and provide their personal health information to Black Swan Health for further assessment

Referrer's signature: _____ Date: __ / ___ / 20____

Print Name: _____