PSYCHOSOCIAL SUPPORTS REFERRAL FORM



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

1. CLIENT DETAILS Title:		
Last Name: First name(s): Address*: Suburb: Postcode: Reason:		
Address*:		
Reason:		
Mobile: Home: Email: Is an interpreter required? Yes No Language spoken at home: Is an interpreter required? Yes No Emergency contact / Next of Kin name: Phone: Phone: Phone: 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 Position: Position: Organisation / provider name: Position: Position: Postcode: Postcode: Address:		
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Organisation / provider name:		
Address: Postcode: Phone: Fax: Email: 3. GP DETAILS GP's name: GP Stamp: GP's practice:		
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GP's name: GP's practice: Address: Suburb: Phone: Fax: Email:		
GP's practice:		
Address: Suburb: Phone: Fax:		
Suburb: Postcode: Phone: Fax: Email:		
Phone: Fax: Email:		
4 REFERRAL INFORMATION		
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Is the client receiving Disability Support Pension?		
* 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 BSH Yes NO Psychosocial Supports?		
Has the client been referred to any other services?		
Does the client have a current risk assessment? (please attach if Yes) Yes No		

Black Swan Health Limited (ABN 64 169 929 677)

North Metro area t: 08 9201 0044 f: 08 9201 0033 e: psychosocial@blackswanhealth.com.au

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To be eligible for Psychosocial Supports, 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:

*Please comment if there is current suicidal ideation

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 supports and coordination arrangements are not in place or have failed Referrer notes:

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

5. CONSENT TO REFERRAL

Please tick the appropriate boxes below. Black Swan Health Psychosocial Supports 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 crit Health	teria for a referral to Black Swan
I have obtained verbal consent from the client / legal guardian to re health information to Black Swan Health for further assessment	efer and provide their personal
Referrer's signature:	Date: / / 20
Print Name:	

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Corporate office: 137-151 Main Street, Osborne Park, WA 6017 Service locations: Osborne Park | Joondalup | Midland | Fremantle www.blackswanhealth.com.au