**COMMONWEALTH PSYCHOSOCIAL SUPPORT PROGRAM**

**(CPSP) REFERRAL**

| **Referral Date:**  |  | **Consumer consent for this referral***:* **☐**Yes ☐ No  |
| --- | --- | --- |
| **REFERRER DETAILS** |
| **Name:** |  | **Organisation:** |  |
| **Phone:** |  | **Email:** |  |
| **Address:** |  |
|

| **ELIGIBILITY CRITERIA** |
| --- |
| **Consumer lives in Torres Strait?** | **YES/NO** | **Consumer is over the age of 18?** | **YES/NO** |
| **Consumer has severe mental health illness?** | **YES/NO** | **Diagnosis/Disability?** |  |
| **Consumer requires support in one or more areas to build capacity and stability. (Please Tick)** | ☐ Social skills and friendships☐ Family connections☐ Managing daily living needs☐ Financial management and budgeting☐ Finding and maintaining a home☐ Vocational skills and goals, including volunteering | ☐ Educational and training goals☐ Maintaining physical wellbeing, including exercise☐ Managing drug and alcohol addictions, including tobacco☐ Building broader life skills including confidence and resilience. |

**CONSUMER DETAILS** |
| **Name:**  |  | **Preferred Name:**  |  |
| **D.O.B.** |  | **Gender:** |  |
| **☐ Aboriginal ☐ Torres Strait Islander ☐ Both** **☐ Neither** | **☐ Culturally & Linguistically Diverse Background** |
| **Address:** |  |
| **Phone numbers:** |  |
| **Email:** |  |
| **Carer/****Support Name:**  |  | **Relationship to you:** |  |
| **Contact details:** |  |

| **ADDITIONAL INFORMATION:** |
| --- |
| **Reason for Referral:**  |  |
| **Consumer goals and hopes:**  |  |
| **Medication details:** *(if applicable)* |  |
| **Outcomes/scores of any relevant psychosocial assessments:** (*e.g. K5, K10, SDQ*) |  |
| **Risk of harm to self:** | Is the person currently self-harming  **☐** Yes ☐ NoIs the person at increased risk of suicide ☐ Yes ☐ No *\*If assessed at high risk of suicide please contact Emergency Services on 000 or go to the Hospital Emergency Department)* |
| **List any other services the consumer is accessing:**  |  |
| **List and attach relevant information/Reports:** *(Please attach to this referral form)* |  |
| **Are there any risk factors** **we should be aware of?** | ☐ No ☐ Yes (please specify below or attach existing risk assessment) |

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| **Home Visit Risk Assessment**  | Does the consumer live alone? If No, is it safe to enter the home? | ⬜ Yes ⬜ No⬜ Yes ⬜ No |
| --- | --- | --- |
| Are there any aggressive animals? | ⬜ Yes ⬜ No |
| Is there any clutter or tripping hazards? | ⬜ Yes ⬜ No |
| Does anyone at the home have a history of violence? | ⬜ Yes ⬜ No |
| Does anyone at the home have any substance abuse? | ⬜ Yes ⬜ No |
| Are there firearms in the home? | ⬜ Yes ⬜ No |
| Does anyone at home have an infectious disease? | ⬜ Yes ⬜ No |
| Is there mobile phone service at the home? | ⬜ Yes ⬜ No |
| Will there be anyone else present at the home at the time of the support? *(If yes, please provide details)* | ⬜ Yes ⬜ No |
| Are there any other risks that affect the clinician safety and wellbeing by accessing the home? | ⬜ Yes ⬜ No |
| Is there a space for the clinician and consumer to meet privately? | ⬜ Yes ⬜ No |
| Are there any risks that affect the clinician safety and wellbeing when assisting in the community? | ⬜ Yes ⬜ No |
| **If any risks are identified, further assessment will be conducted prior to the home visit.**  |

**CONSUMER PREFERENCES:** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Preferred Gender of Worker:** | ☐ Don’t mind ☐ Female  ☐ Male |
| **Preferred contact methods:** | \*Ok to leave voicemail/send SMS: ☐ Yes ☐ No☐ Mobile ☐ Home phone ☐ Email ☐ via Referrer \*If we can’t reach the consumer on the phone do they consent to a home visit?: ☐ Yes ☐ No\*Is it ok to leave letter/card at home: ☐ Yes ☐ No  |
| **Other preferences:** |  |

**Please return form to Wakai Waian Healing by either of the following means:**

**Email:** referralsti@wakai-waian.com.au

**Fax:** 07) 4829 4011

**Postal:** Wakai Waian Healing, P.O. Box 767, Thursday Island QLD 4675.

**In person:** 40 Douglas Street, Thursday Island QLD 4675.

**For more information:**

Freecall: 1800 732 850

Email: referralsti@wakai-waian.com.au