**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 ☐ No  Is 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) |

| | **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](mailto: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](mailto:referralsti@wakia-waian.com.au)