
Ruah Inreach Specialist Recreation Service
REQUEST FOR SERVICE

We ask that this form be read and signed by the person requesting service,
marked **CONFIDENTIAL** and **POSTED** to:

Inreach Specialist Recreation Service
Fremantle District:
Level 1/3 Norfolk Street
Fremantle 6160

Inreach Specialist Recreation Service
Lower North Region:
P.O. Box 584
Mt Hawthorn 6915

DETAILS OF PERSON BEING REFERRED

Name: _____		DOB: __ __ __	
Address: _____			
_____		Pcde: _____	
Email _____	Ph _____	Mob _____	
Best way of contact _____			
Country of Birth: _____		Language spoken at home: _____	

DETAILS OF REFERRER

Name _____		Position _____	
Agency _____		Ph _____	
Email _____			
Address _____			
_____		Pcde _____	
Referral Date: __ __ __			

MEDICAL/CLINICAL CARE ARRANGEMENTS

CURRENT TREATING DOCTOR:			
Name _____			
Email _____		Ph _____	
Address _____			
_____		Pcde _____	

KEY WORKER OR CASE MANAGER:

Name _____ Position _____

Ph _____ Email _____

Address _____

_____ Pcde _____

HEALTH HISTORY

Diagnosis: _____

Current medication: _____

Does this person have a history of self-harm? _____

Does this person have a history of harming others? _____

List any significant substance use:

Current: _____

Past: _____

Tobacco use: _____

List any physical illness: _____

Level of fitness (please comment): _____

SOCIAL NETWORKS

Tick boxes to indicate who makes up the person's social networks:

Parent(s)

Siblings

Friends

Other

Health Professional

Significant other/partner

Don't know

List any other support networks this person has: _____

List the reasons for the referral: _____

Is this person prepared to work in partnership with a Ruah worker? Yes No

REFERRER'S SIGNATURE

SIGNATURE OF PERSON REQUESTING SERVICE
AND CONSENT TO BE REFERRED