



# Intensive Program REFERRAL FORM

Please provide the following information if known or mark 'n/a' where not applicable.

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## DETAILS OF PERSON REQUIRING SERVICES (person being referred)

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Country of birth: \_\_\_\_\_ First language: \_\_\_\_\_

Living arrangements (residing with parents? friends? partner? Are there children?): \_\_\_\_\_

Current address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Known phone number/s: \_\_\_\_\_

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Known diagnosis/diagnoses: \_\_\_\_\_

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## REASON FOR REFERRAL (brief overview of support needs):

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## CURRENT/RECENT TREATING CLINICIAN/S (eg psychiatrist, GP, specialist):

Name: \_\_\_\_\_

Service: \_\_\_\_\_

Contact number: \_\_\_\_\_

How long has the above service been involved? \_\_\_\_\_

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Name: \_\_\_\_\_

Service: \_\_\_\_\_

Contact number: \_\_\_\_\_

How long has the above service been involved? \_\_\_\_\_



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CURRENT MEDICATIONS (please list dosages also)

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KNOWN SUBSTANCE USE - please list (including prescription drugs if applicable):

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RISK (the following information is required under Duty of Care provision and will be treated confidentially)

Does this person have a history of harming **self or others**? Please detail:

Please note any known offending history:

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Does the person know about this referral? (please circle)      Yes      /      No

Signed (Referrer):

Date:

DETAILS OF REFERRER (person completing the form)

Name:

Date:

Service:

Contact number:

How long have you known/worked with this person?

Please address to:  
**Manager - Intensive Program**  
**PO Box 218 Leederville 6903**  
or via  
Fax: **08 9443 6422** Att: **Manager**

Please attach any further information where possible