BALLARAT COMMUNITY HEALTH CENTRE INC.
Reg No. A0027447C
POSTAL ADDRESS: P O BOX 1156 BALLARAT MAIL CENTRE 3354

BCHC P.D.R.S. REFERRAL FORM

CLIENT DETAILS

NAME: ……………………………………………………………………………..

AGE: ………… **D.O.B.:** …../…../….. **M / F (circle)**

ADDRESS: ……………………………………………………………………………..

……………………………………………. **POST CODE:**…………….

PHONE: ………………………………. **FAX:** ………………………………...

MOBILE: ……………………………… **EMAIL:** ……………………………..

Is an interpreter required ☐ **Yes Specify language** …………….. ☐ **No**

SERVICE REQUESTED (Please tick the service requested)

☐ **Home-Based Outreach** (*Central Highlands Region)*

Support is provided to people in their own home who are experiencing a mental illness. Carers are also offered respite by this service.

☐ **Movin On**

Offers support to 18 – 30 year olds with a history of Psychosis. It provides a 'return to work or study' option.

☐ **APROTCH – Day Programs**

Offers psychosocial rehabilitation activities in an day program setting.

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SOURCE OF REFERRAL

Please tick referral source.

Self: ☐ **Carer:** ☐ **Case Manager:** ☐ **Support Worker:** ☐ **GP:** ☐ **Other:** ☐

Contact Details:

NAME: …………………………………………………………………………..

ADDRESS: …………………………………………………………………………..

………………………………………… **POST CODE:**……………

PHONE: ……………………………. **FAX:** ……………………………

MOBILE: …………………………… **EMAIL:** ………………………..

PLEASE LIST SUPPORT REQUIREMENTS:

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PSYCHIATRIC HISTORY AND DIAGNOSIS

☐ **Clinical report attached including ISP/IPP (Case Managed Client)**

☐ **Explanation of psychiatric condition (non Case Managed Client)**

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MEDICAL HISTORY

Please list any medical illnesses (past or present) that the program should be aware of ie. Hepatitis, Epilepsy, Diabetes, Cardiac condition, Allergies etc.

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BCHC P.D.R.S. REFERRAL FORM

FORENSIC HISTORY

Aggression to others ☐ **Aggression to self:** ☐

Aggression to property: ☐ **Court involvement:** ☐

Juvenile Justice Department: ☐ **Inpatient unit:** ☐

INCOME DETAILS

Please tick income source.

Centrelink: ☐ **Wage:** ☐ **Other:** ☐

If other please supply details: ……………………………………………………..

……………………………………………………..

PRIVACY

BCHC under P.D.R.S. is required under Federal and State law to protect the privacy of any person being referred to the service.

Has client consented to sharing information with this agency. ☐ **Yes** ☐ **No**

APPLICANT'S SIGNATURE

Applicant's Signature: ……………………………. **Date:…../…../…..**

Unsigned referral will not be processed

Copy given to

Consumer ☐

Carer ☐

Referral Source ☐