FAMILY AND CARERS MENTAL HEALTH
SERVICE PROVIDER REFERRAL FORM

Which LHD does this person live in?

☐ Central Coast ☐ Northern Sydney
☐ Nepean Blue Mountains ☐ Western Sydney

Is this person a carer or relative of a person with a mental illness? ☐ Yes ☐ No

Has this person consented to this referral? ☐ Yes ☐ No

If you have answered 'no' to any of the above questions, or the person does not live in one of the above LHDs, your referral may not be accepted. Please contact us and we'll talk you through some other options.

Please note that receipt of the referral does not indicate acceptance to FCMH. The suitability of the referral will be determined following review by our staff. If you have any queries about your referral, please contact the respective office on the numbers below and we can discuss further.

If the client needs urgent assistance, please call the Mental Health Line on **1800 011 511**, Lifeline on **13 11 14**, dial **000**, or go to the nearest hospital emergency department.

Section 1: APPLICANT DETAILS

First Name: ..... Last Name: .....

Gender: ..... Preferred Pronoun(s): .....

Date Of Birth: .....

Country of Birth: ..... Identified Culture:

Preferred Language: ..... Language Spoken at Home: .....

Interpreter Needed: ..... Interpreter Language: .....

Phone Number: .....

Mobile Number: .....

Email Address: .....

Address: .....

Suburb: ..... Postcode: .....

Does the Applicant Identify As:

☐ Aboriginal ☐ Aboriginal and Torres Strait Islander
☐ Torres Strait Islander ☐ Neither

Marital Status:

☐ Never married / Single ☐ Separated
☐ Married (registered and de facto) ☐ Divorced
☐ Widowed

Housing Status:

- ☐ Owned Home (including purchasing)
- ☐ Social Housing Aboriginal
- ☐ Community Housing
- ☐ Emergency Housing
- ☐ Private Rental
- ☐ Boarding House
- ☐ Public Housing
- ☐ Homeless

Living Arrangement (tick as many as applicable):

- ☐ Lives with parent(s)/guardian(s)
- ☐ Lives alone
- ☐ Lives with other family
- ☐ Lives with partner
- ☐ Lives with children

Employment Status:

- ☐ Full-time employment
- ☐ Casual employment
- ☐ Unemployed
- ☐ Not in labour force
- ☐ Part-time employment
- ☐ Studying at school
- ☐ Studying at university/TAFE

Income Source (tick as many as applicable):

- ☐ N/A – not in labour force
- ☐ Paid employment
- ☐ Disability Support Pension
- ☐ Other pension or benefit
- ☐ Carer allowance
- ☐ Carer payment
- ☐ Other
- ☐ Nil income

Allergies:

☐ Yes ☐ No

Details: .....

Dietary Requirements:

☐ Yes ☐ No

Details: .....

NDIS Involvement:

☐ Yes ☐ No

Details: .....

Section 2: NEXT OF KIN / EMERGENCY CONTACT

Full Name: .....

Relationship to Applicant: .....

Phone Number: .....

Do we have permission to speak to this person? ☐ Yes ☐ No

Section 3: DETAILS OF CARING ROLE

How long has this person been in a caring role: .....

Please provide details of all people that the applicant is caring for:

Consumer 1

Name: ..... Age: ..... Gender: .....

Applicant's relationship with consumer: .....

Primary Mental Illness: .....

Secondary Mental Illness(es): .....

Does consumer also have: ☐ Intellectual Disability ☐ Acquired Brain Injury ☐ Drug/Alcohol Abuse ☐ Physical Disability

Does the applicant live with the consumer: ☐ Yes ☐ No ☐ Not known

Has consumer had contact with the LHD in last 6 months: ☐ Yes ☐ No ☐ Not known

Is consumer's mental health managed by primary care / private health professional: ☐ Yes ☐ No ☐ Not known

Consumer 2

Name: ..... Age: ..... Gender: .....

Applicant's relationship with consumer: .....

Primary Mental Illness: .....

Secondary Mental Illness(es): .....

Does consumer also have: ☐ Intellectual Disability ☐ Acquired Brain Injury ☐ Drug/Alcohol Abuse ☐ Physical Disability

Does the applicant live with the consumer: ☐ Yes ☐ No ☐ Not known

Has consumer had contact with the LHD in last 6 months: ☐ Yes ☐ No ☐ Not known

Is consumer's mental health managed by primary care / private health professional: ☐ Yes ☐ No ☐ Not known

Consumer 3

Name: ..... Age: ..... Gender: .....

Applicant's relationship with consumer: .....

Primary Mental Illness: .....

Secondary Mental Illness(es): .....

Does consumer also have: ☐ Intellectual Disability ☐ Acquired Brain Injury ☐ Drug/Alcohol Abuse ☐ Physical Disability

Does the applicant live with the consumer: ☐ Yes ☐ No ☐ Not known

Has consumer had contact with the LHD in last 6 months: ☐ Yes ☐ No ☐ Not known

Is consumer's mental health managed by primary care / private health professional: ☐ Yes ☐ No ☐ Not known

Section 4: REASONS FOR REFERRAL

How can Family and Carers Mental Health support the applicant?

- ☐ Information
- ☐ Education and training
- ☐ Building a support network
- ☐ Access to carer support groups
- ☐ Emotional support
- ☐ Advocacy
- ☐ Linking with professional services
- ☐ Other goals, please specify below:

Section 5: SAFETY CONSIDERATIONS FOR APPLICANT

Suicide? ☐ Yes ☐ No

Details: .....

Non-accidental self-injury? ☐ Yes ☐ No

Details: .....

Substance use? ☐ Yes ☐ No

Details: .....

Past physical or verbal aggression? ☐ Yes ☐ No

Details: .....

At risk of homelessness? ☐ Yes ☐ No

Details: .....

Risk taking and/or impulsive behaviour? ☐ Yes ☐ No

Details: .....

Section 6: ADDITIONAL INFORMATION

Please outline any additional information, history, or anything else you or the applicant would like to add:

Section 7: REFERRING AGENT DETAILS

Referring Agent Name: .....

Service/Organisation: .....

Designation: .....

Telephone: ..... Fax: .....

Email: .....

Referral Date: .....

All referrals to be emailed to:

Central Coast / Northern Sydney: familycarernscc@parramattamission.org.au
Nepean Blue Mountains / Western Sydney: fcmhinfo@parramattamission.org.au

For enquiries please contact the relevant office on the numbers below:

Central Coast:	(02) 4322 1855	Northern Sydney:	(02) 8599 4855
Nepean Blue Mountains:	(02) 8880 8160	Western Sydney:	(02) 8599 4880

The referring agent and applicant will be contacted within 3 business days after receipt of the referral to discuss the next steps.