

PIR Organisation Referral Form

Please complete this form with any additional supporting information via secure fax to **6100 9961**.

If there is any missing information, it will be returned to be completed.

PIR Eligibility Criteria – The following criteria must be met:	
	aged 18 years and over and under the age of 65 years
	a resident of the ACT
	has a formal diagnosis of a severe and persistent mental health condition and can provide evidence
	not currently accessing any other care coordination services to assist in accessing the necessary service they require
	not currently receiving a NDIS funded plan
	informed about the program, consented to this referral and is willing to engage

Areas of need				
Please indicate which life domains require service links/support – tick all that apply				
Physical Health	Alcohol and drugs	Family	Legal issues	Interpersonal Connectedness
Lifestyle	Education/Employment	Finance	Accommodation	Other

Participant Demographic Details	
Full Name:	Date of Birth:
Address:	Postcode:
	Contact No.:
Gender:	Email:
Marital Status:	
Aboriginal or Torres Strait Islander Status:	
Country of Birth:	If not born in Australia, year of first arrival in Australia:
Main Language Spoken at Home:	Interpreter Required: Language:
Current Living Arrangements:	Income Source:
Carer/Guardian or Next Of Kin Details	
Name:	Relationship:
Address:	Contact No.:
Additional Information	
Current Health or Other Community Support Services Provided: Please list Service Name/Type:	
Co-existing factors that impact on client functioning:	
Court and Statutory Orders:	
Are there any risk related behaviour/s that the Participant has engaged with in the past 6 months? <i>Please attach any risk management plans to this referral if available.</i> NB: This is not a crisis service, if the Participant needs immediate assistance, please call the Crisis Assessment and Treatment Team (CATT) on 1800 629 354	
Are there any concerns about the person's capacity to make decisions? Please provide details	
Service Preference	
(every effort will be made to meet these preferences; however, program capacity may influence the outcome)	
Support Facilitator Gender Preference:	
Support Facilitator Aboriginal or Torres Strait Islander Preference:	
Preferred Service Provider:	
Referral Completed by	
Contact Name:	Organisation:
Phone:	Email:
Referrer's Signature:	Date:

Please note: Acceptance of a referral means that the client is eligible under the PIR Eligibility Criteria – it does not necessarily mean that they will be accepted into the PIR Program for ongoing assistance.
Please make this clear to your client when submitting a referral.