**Client Referral Form**

**Please complete the below form and email to** [**referrals@insideoutrecovery.com.au**](mailto:referrals@insideoutrecovery.com.au)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client Details** | | | | | | | | | | | | | | | | |
| **Basic Information** | | | | | | | | | | | | | | | | |
| **Name:** | | |  | | | | | | **DOB:** | | | | |  | | |
| **Address:** | | |  | | | | | | | | | | | | | |
| **Contact number** | | | Home: | | |  | | | | | Mobile: | | |  | | |
| **Email:** | | |  | | | | | | | | | | | | | |
| **Preferred contact method:** | | | Phone  Email  Face-to-face  Letter  Other, please state: | | | | | | | | | | | | | |
| **Contacts** | | | | | | | | | | | | | | | | |
| **Alternative Contact:** | | | Contact Person: | | | | | |  | | | | | | | |
| Phone: | | | | | |  | | | | | | | |
| Email: | | | | | |  | | | | | | | |
| Relationship to Client: | | | | | |  | | | | | | | |
| **Emergency Contact:**  As above | | | Contact Person: | | | | | |  | | | | | | | |
| Phone: | | | | | |  | | | | | | | |
| Email: | | | | | |  | | | | | | | |
| Relationship to Client: | | | | | |  | | | | | | | |
| **Advocacy Support:** | | | Contact Person: | | | | | |  | | | | | | | |
| Phone: | | | | | |  | | | | | | | |
| Email: | | | | | |  | | | | | | | |
| **Guardianship Orders:**  Financial  Decision Maker | | | Company Name: | | | | | |  | | | | | | | |
| Contact Person: | | | | | |  | | | | | | | |
| Phone: | | | | | |  | | | | | | | |
| Email: | | | | | |  | | | | | | | |
| **Background Information** | | | | | | | | | | | | | | | | |
| **Do you identify as Aboriginal or Torres Strait Islander?**  (Please select all that apply) | | | | Yes, Aboriginal  Yes, Torres Strait Islander  No  Prefer not to answer | | | | | | | | | | | | |
| **Cultural background:** | | | |  | | | | | | | | | | | | |
| **Language spoken at home:** | | | |  | | | | | | | | | | | | |
| **Gender:** | | | | Male  Female  Please specify: | | | | | | | | | | | | |
| **Pronouns:**  (Please select all that apply) | | | | He  Him  She  Her  They  Them  Please specify:  Prefer not to answer | | | | | | | | | | | | |
| **Relationship status:** | | | |  | | | | | | | | | | | | |
| **Do you identify as LGBTQ+?** | | | | Yes  No  Prefer not to answer | | | | | | | | | | | | |
| **Residence** | | | | | | | | | | | | | | | |
| **Housing Type:** | | | | Housing NSW  Community Housing  Social Housing  Homeless  Temporary Housing  Boarding House  Shared Accommodation  Private Rental  Homeowner  Please specify: | | | | | | | | | | | |
| **Are there tenancy concerns?** | | | | No  Yes, please describe: | | | | | | | | | | | |
| **Time at current address:** | | | |  | | | | | | | | | | | |
| **Who else lives at this address:** | | | |  | | | | | | | | | | | |
| **Are there any child protection issues?** | | | | No  Yes, please describe: | | | | | | | | | | | |
| **Are there any pets?** | | | | No  Yes, please complete the following: | | | | | | | | | | | |
| How many pets: | | | | | | | |  | | | |
| Pet type: | | | | | | | |  | | | |
| Is the RSPCA involved? | | | | | | | |  | | | |
| **Other Services Involved** | | | | | | | | | | | | | | | |
| **Name** | | **Position** | | | **Organisation** | | | **Contact Number** | | **Contact Email** | | | **Assisting with?** | | **Contact?** |
|  | |  | | |  | | |  | |  | | |  | | Yes  No |
|  | |  | | |  | | |  | |  | | |  | | Yes  No |
|  | |  | | |  | | |  | |  | | |  | | Yes  No |
|  | |  | | |  | | |  | |  | | |  | | Yes  No |
|  | |  | | |  | | |  | |  | | |  | | Yes  No |
|  | |  | | |  | | |  | |  | | |  | | Yes  No |
| **Other Concerns** | | | | | | | | | | | | | | | | |
|  | **Concern** | | | | | | **Comment** | | | | | | | | | |
|  | Drug use | | | | | |  | | | | | | | | | |
|  | Alcohol use | | | | | |  | | | | | | | | | |
|  | Excessive gambling | | | | | |  | | | | | | | | | |
|  | Excessive shopping | | | | | |  | | | | | | | | | |
|  | Domestic and family violence | | | | | |  | | | | | | | | | |
|  | Housing issues | | | | | |  | | | | | | | | | |
|  | Custody issues | | | | | |  | | | | | | | | | |
|  | Current legal matters | | | | | |  | | | | | | | | | |
|  | Local council involvement | | | | | |  | | | | | | | | | |
|  | Financial matters | | | | | |  | | | | | | | | | |
|  | Trauma | | | | | |  | | | | | | | | | |
|  | Grief and loss | | | | | |  | | | | | | | | | |
|  | Anxiety | | | | | |  | | | | | | | | | |
|  | Depression | | | | | |  | | | | | | | | | |
|  | Other Mental Illness | | | | | |  | | | | | | | | | |
|  | Other concerns (Please specify) | | | | | |  | | | | | | | | | |

|  |  |
| --- | --- |
| **Please provide any additional information that will assist Inside Out Recovery to deliver supports and trauma-informed service appropriately:** |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Referring Agency** | | | | | | |
| **Referrer’s Name:**  Self-referral |  | | **Referrer’s position:** | |  | |
| **Program name:** |  | | | | | |
| **Business address:** |  | | | | | |
| **Contact numbers:** | Office: |  | | Mobile: | |  |
| **Has the client provided consent for the referral?** | Yes, written consent  Yes, verbal consent  No, please provide details: | | | | | |

| **Funding Details** | | | |
| --- | --- | --- | --- |
| **Funding Type** | **Details** | | |
| **NDIS plan**  ***(Continued on next page)***  **NDIS plan *(continued)*** | NDIS number: |  | |
| NDIS plan dates: |  | |
| Is support required for the duration of the plan, or a set amount of time? | Duration of plan  Set period, please specify: | |
| **Support Coordinator/LAC details** | | |
| Contact person: |  | |
| Company name: |  | |
| Phone: |  | |
| Email: |  | |
| **NDIS Funding Details** | | |
| How is the NDIS funding managed: | NDIA-managed  Self-management  Plan-managed, please complete below | |
| **Plan Manager Details** | | |
| Company name: |  | |
| Contact person: | Name: |  |
| Phone: |  |
| Email: |  |
| Plan Manager Invoices: | Name: |  |
| Phone: |  |
| Email: |  |
| **My Aged Care** | My Aged Care number: |  | |
| Aged Care package level: |  | |
| Company name: |  | |
| Contact person: | Name: |  |
| Phone: |  |
| Email: |  |
| Invoices: | Name: |  |
| Phone: |  |
| Email: |  |
| **Brokerage Funder** | Company name: |  | |
| Contact person: | Name: |  |
| Phone: |  |
| Email: |  |
| Invoices: | Name: |  |
| Phone: |  |
| Email: |  |
| **Fee for service**  Client is paying for the service | Contact person: | Name: |  |
| Phone: |  |
| Email: |  |
| Invoices and payments | Name: |  |
| Phone: |  |
| Email: |  |
| **Other (please state)** |  | | |