**Client Referral Form**

**Please complete the below form and email to** **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)** |  |