

Recovery Options referral form.

Uniting WA is a NDIS registered provider (mental health & disability).

Participant details	
Name:	Date of birth:
Phone:	Mobile:
Address:	
Suburb:	Postcode:
Cultural background:	Gender:
Interpreter required: Yes □ No □	
Language/Dialect:	
Is the applicant aware of the referral? Yes \Box	No □
Referrer details (if applicable)	
Name:	_ Position:
Phone:	_Mobile:
Organisation:	
Address:	
Email:	
Alternative contact for Participant (contact will be used if unable to contact Participant directly)	
Name:	_ Relationship:
Phone:	Mobile:

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Areas where support may be required Communication and relationships □ Learning skills □ Taking care of yourself □ Strategies at times of distress Community connection Getting places □ Other Are there any known safety concerns to self, others, or environment? Yes □ No □ Details: Does the person have a history of suicidal thoughts or actions? Yes □ No □ Does the applicant have a mental health diagnosis? Yes □ No □ Details: Does the applicant have any other diagnosed disabilities? Yes □ No □ Details: _____ Is the applicant a permanent resident or citizen of Australia? Yes □ No □ Details: Is the applicant dependent on alcohol or other drugs? Yes □ No □

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Does the applicant receive support from any oth	ner services?
Yes □ No □	
Details:	
Case Manager:	Phone:
GP:	Phone:
Is the applicant interested in information about	the NDIS?
Yes □ No □	
Is the applicant willing to work with a Support W	Vorker to develop an Individual Recovery Plan?
Yes □ No □	
Agreement	
For the purpose of assessing eligibility for the pro	ogram, I give consent for Uniting WA to contact and
liaise with persons/services that I specify on this	form.
Participant name:	
Participant signature:	
Date:	
Referrals can be sent to Uniting WA by:	
Post: 56 Baltimore Parade, Merriwa, 6030	
Phone: 08 9206 6200 Fax: 08 9206 6222	
Email: recoveryoptions@unitingwa.org.au	
Service Area: Perth North Primary Health Networ	rk Region

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