Participant Details

|  |  |
| --- | --- |
| **Name:** |  |
| **Preferred Name** (f any)**:** |  |
| **Date of Birth:** |  |
| **Address:** |  |
| **Phone Number:** |  |
| **Email:** |  |
| **Preferred Contact Method:** |  |
| **Main Language Spoken:** |  |
| **Interpreter Required:** |[ ]  Yes, please specify language: |  |[ ]  No |
| **Gender:** |[ ]  Male |[ ]  Female |[ ]  Non-Binary |
|  |[ ]  Prefer not to say |[ ]  Other, please specify: |  |
| **Preferred Pronouns:** |  |

Areas of Support

|  |  |  |  |
| --- | --- | --- | --- |
| **Social skills, friendships, and family connections** | Yes [ ]  | No [ ]  | Details: |
| **Taking care of yourself and your mental wellbeing** | Yes [ ]  | No [ ]  | Details: |
| **Building life skills and improving day to day living** | Yes [ ]  | No [ ]  | Details: |
| **Vocation and Employment**  | Yes [ ]  | No [ ]  | Details: |
| **Is the person receiving support from any other services?** | Yes [ ]  | No [ ]  | Details: |

Safety and Risk

|  |  |  |  |
| --- | --- | --- | --- |
| **Does the person have a mental health diagnosis?** | Yes [ ]  | No [ ]  | Details: |
| **Are there any known safety concerns to self, others, or environment?** | Yes [ ]  | No [ ]  | Details:  |
| **Has the person had suicidal ideation in the last 7 days?** | Yes [ ]  | No [ ]  | Details:  |
| **Is the person dependent on alcohol or other drugs?**  | Yes [ ]  | No [ ]  | Details:  |
| **Does the person have any other diagnosed disabilities?** | Yes [ ]  | No [ ]  | Details: |

Referrer Details

|  |  |
| --- | --- |
| **Name:** |  |
| **Position:Organisation:** |  |
| **Contact Details:** |  |

Alternative Contact

|  |  |
| --- | --- |
| **Name:** |  |
| **Relationship:** |  |
| **Phone or Contact Details:** |  |

Return to : Recoveryoptions@unitingwa.org.au