THE BUTTERY
ENRICHING LIVES

# PARTICIPANT REFERRAL FORM

***Please return completed form to intake@buttery.org.au or fax 02) 6687 1039***

## SECTION 1. REFERRAL DETAILS

| | | | |
|---|---|---|---|
| **Referral date** | | **Time** | |
| **Staff member name** | | **Staff member Phone** | |
| **Program/service of interest** | | | |

| **Referral organisation details** (*To complete only if referral from another organisation it's been made.*) | | | |
|---|---|---|---|
| **Organisation name** | | | |
| **Address** | | | |
| **Hours of operation** | | **Name of program** | |
| **Contact name** | | | |
| **Phone** | | **Mob:** | |
| **Participant consent for referral** | ☐ Yes ☐ No | | |
| **Reason for referral** | | | |
| **Issues identified by referring agency** | | | |
| **Any risks?** | Self-harm ☐ High ☐ Medium ☐ Low<br>Suicidal ☐ High ☐ Medium ☐ Low<br>To others ☐ High ☐ Medium ☐ Low | | |

| **Referral made by** | | |
|---|---|---|
| ☐**Phone** | ☐**Face to face** | **Other (specify):** |

## SECTION 2. PARTICIPANT CONSENT

| Participant consent |
|---|
| I, _____ understand and agree for The Buttery to receive my personal details. I understand my involvement in this process is voluntary and I may withdraw at any time. I also understand that I can withdraw my consent at any time. I give consent to share information relating to my treatment and needs.<br><br>**Consent type** : ☐Verbal - Date: _____/_____/_____Time of consent: _____<br>☐Written - Time of consent:_____<br><br>**Participant signature**:_____ Date: _____/_____/_____ |

## SECTION 3. PARTICIPANT DETAILS

| | | | |
|---|---|---|---|
| **Participant name** | | **Reference #** | |
| **Address** | | **Date of birth** | |
| **Phone** | | **Mobile** | |
| **Cultural background** | | **Language spoken** | |
| **Interpreter required** | ☐ **Yes** ☐ **No** | **Gender** | ☐ **F** ☐ **M** |

| **Participant emergency contact details** | | | |
|---|---|---|---|
| **Full name** | | | |
| **Relationship** | | | |
| **Address** | | | |
| **Phone** | | **Mobile** | |
| **Email** | | | |
| **Preferred method of contact** | ☐ **Mail** ☐ **Phone** ☐ **Mobile** ☐ **Email** | | |

## SECTION 4. PARTICPANT INFORMATION ON REFERRAL

| Current personal situation | | | |
|---|---|---|---|
| **Summary of services and treatment** | | | |
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| | | | |
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| | | | |
| **Client lives** | **Benefits** | **Education** | **Employment** |
| ☐ Alone<br>☐ With family/carer<br>☐ Other<br><br>Please specify: | ☐ Yes<br>☐ No<br><br>If so, what type? | ☐School<br>☐University<br>☐TAFE<br>☐ Other<br>Please specify: | ☐Full-time<br>☐Part-time<br>☐Casual<br>☐Seeking employment |
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| **Family and social support** | | | |
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| **Health issues** | | | |
| **Physical** | | **Mental Health** | |
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| **Medication** | | | |
| | | | |
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| **Lifestyle activities** | | | |
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| **Legal issues** | | | |
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## SECTION 5. REFERRAL OUTCOME

| **Referral outcome** | **Follow-up actions** *(e.g. inform participant with letter)* | **Complete** |
|---|---|---|
| ☐ Organise intake process | | ☐ **Yes** ☐ **No** |
| ☐ Provision of service | | ☐ **Yes** ☐ **No** |
| ☐ Place on waiting list | | ☐ **Yes** ☐ **No** |
| ☐ Referral to another agency | | ☐ **Yes** ☐ **No** |
| ☐ Service access decline | | ☐ **Yes** ☐ **No** |
| ☐ Other (specify): | | ☐ **Yes** ☐ **No** |

| | |
|---|---|
| **Date** | |
| **Staff member name** | |
| **Staff member signature** | |

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