

Partners in Wellbeing Intake Referral Form/Screening Tool

Date of Referral

										Date of Referral						
CONSENT																
Have you received informed consent from the person to make a referral to Partners in Wellbeing Program on their behalf?																
Has the person provided consent for their information to be shared for the purposes of making this referral?																
										Date Consent Received:						
REFERRER DETAILS																
Name:					Role:					Organisation/Service						
Contact Number:							Email:									
How should the Partners in Wellbeing team contact the participant for screening?																
What is the reason/s for the referral/support needs?																
What types of supports do you regularly provide to the person you are referring?																
INDIVIDUAL DETAILS																
Surname					Given Name						Other Names:					
Address					Suburb					Postcode						
DOB					Gender					Relationship Status						
Contact Number					Alt. Contact Number:					Preferred method of contact:						
Aboriginal/Torres Strait Islander:							Cultural Background identified:									
Are you an Australian Resident?							Interpreter Required:		Yes				No			
Visa Status							Language required:									
Who can the agency contact if necessary (Emergency contact or a nominated contact person)?																
Name					Relationship to the participant											
Contact Number:					Email											
IMMEDIATE NEEDS																
Does the person have access to food and essentials? (including medication/s)																
Do they have access to a phone and data?																
Do they currently feel unsafe or at risk for any reason?																
Further Information and/or other immediate needs or risks:																
OTHER CURRENT SUPPORT/S																
Does the person receive regular supports from services (other than your service), if known? If yes, please complete the table below																

Name	Organisation	Role	Contact Information (Phone Number/ Email)	Support impacted by COVID-19?	Verbal Consent Given by the person to contact these services
COVID SCREEN (COMPLETE WITH THE PERSON BEING REFERRED)					
1. Are you aware of the symptoms of COVID 19?					
2. Are you or a member of your household displaying symptoms of COVID 19?					
3. Have you been formally diagnosed with COVID 19?					
4. Are you or a member of your household considered High Risk*? <i>*Eg. Respiratory Problems, Age, Autoimmune problem, Asthma and other co-morbidities</i>					
5. Are you currently completing voluntary or mandatory isolation?					
<i>If Yes to q.5, how long have you been in mandatory isolation? Where are you isolating? Reasons why you're isolating?</i>					
Other relevant information related to the impact due to COVID and associated restrictions that are being experienced by the person:					
HOUSING AND LIVING ARRANGEMENT					
Current Living Arrangements:					
Alerts or concerns related to living arrangements e.g. homeless, at risk of homelessness, living in overcrowded housing, experiencing or at risk of family/domestic violence					
EMPLOYMENT & FINANCIAL STATUS					
Employment Status				Current Income Source	
Current Employment/Income Issues (if any):					
OTHER RELEVANT INFORMATION/URGENT NEEDS/IMMEDIATE RISKS:					
Please provide any other information (including risks and complexities)					

Please fax or email completed form to the Partners in Wellbeing Intake Team:
03 9413 7189 or partnersinwellbeing@acso.org.au
If you have any questions please call 1300 375 330

