



URZI PSYCHOLOGY

REFERRAL FORM – Jump Starter Program

The Jump Starter program offers members of our community the opportunity to work alongside skilled staff who have an in-depth understanding of the NDIS and the eligibility criteria. The Jump Starter program will see the client linked in with experts who are able to gather all their supporting information and collate it in a way which maximises their chances of being eligible for NDIS funding. The Jump Starter program utilises the knowledge qualification and skills of the entire Urzi Psychology team, who can complete assessments should additional supporting evidence be required, without any of the extensive wait periods or out of pocket expenses.

By consenting to this referral, the person is consenting to the sharing of their personal information. The information contained in the referral is used by Urzi Psychology to: (1) deliver intake services, (2) for monitoring, aggregate reporting and evaluation purposes to improve quality and access to care. This information will be passed on to the recommended provider who will contact the person.

Please indicate the patient is aware of the information in, and has consented to, this referral Y N

REFERRER DETAILS	
Date of referral:	
Referrer name:	Email:
Organisation:	Postal address:
	Phone:
	Fax:
PATIENT DETAILS	
Patient Name:	DOB:
Preferred Name:	Gender Identity: M F Other
Address:	Home phone:
Postcode:	Mobile Ph:
Experiencing homelessness	
Aboriginal or Torres Strait Islander status:	Aboriginal Torres Strait Islander Both Neither
Culturally or Linguistically Diverse (CALD):	Y N
Language spoken at home:	
Is an interpreter required?	Y N
Emergency Contact Name:	Relationship to person:
Phone Number:	Parent/Guardian/Carer:
MENTAL HEALTH PRESENTATION	

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Presenting issues:					
Principal diagnosis:					
Agoraphobia Social Phobia Panic Disorder OCD	<input type="checkbox"/> Generalised Anxiety Depressive symptoms Bipolar Disorder Major Depressive Disorder	Adjustment Disorder Oppositional Defiance Disorder Personality Disorder Conduct Disorder	Alcohol Dependence Drug Dependence Schizophrenia Other:		
Severity:	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Complex	
Family History of Mental Illness: <input type="checkbox"/> Y <input type="checkbox"/> N					
Risk of Harm to self or others:	<input type="checkbox"/> No identified risk	<input type="checkbox"/> Low risk	<input type="checkbox"/> Moderate risk	<input type="checkbox"/> High risk	
Is the person currently self-harming? <input type="checkbox"/> Y* <input type="checkbox"/> N					
Is the person at increased risk of suicide? <input type="checkbox"/> Y* <input type="checkbox"/> N					
**Please note this is not a crisis service. If assessed at very high risk of harm, please contact Emergency Services on 000 or Acute Care Team on 1300 642 255.					
Functional impairment:	<input type="checkbox"/> No problems	<input type="checkbox"/> Mild impact	<input type="checkbox"/> Moderate impact	<input type="checkbox"/> Severe impact	<input type="checkbox"/> Very severe to extreme impact
Medications:					
What existing services are being accessed? (Please outline below)					
<input type="checkbox"/> Psychologist: <input type="checkbox"/> Psychiatrist: <input type="checkbox"/> General Practitioner:			<input type="checkbox"/> Occupational Therapist: <input type="checkbox"/> Physiotherapist: <input type="checkbox"/> Other:		
Additional information not included in referral (please attach any relevant reports):					
Goals and Hopes of the Patient:					

Forward completed Referral via Medical Objects to Dino Urzi (Urzi Psychology) or e mail to admin@urzipsychology.