Referral to PHaMs UnitingCare West

The Personal Helpers and Mentors program (PHaMs) aims to assist people aged 16 years and over whose ability to manage every day activities is severely limited due to mental health issues.

The Scarborough, Joondalup and Clarkson areas accept referrals for people living in the following postcodes, or who are homeless but primarily live within the following postcodes:

CATCHMENT AREAS for SCARBOROUGH	for JOONDALUP & CLARKSON
6018, 6019, 6020, 6029	6023, 6024, 6025, 6026, 6027, 6028, 6030, 6034, 6035, 6036, 6037, 6038

In special circumstances there is flexibility.

1. Does the applicant identify as having a mental illness? Yes ☐ No ☐
2. Is the applicant willing to work with a Community Support Worker in developing an Individual Recovery Plan? Yes ☐ No ☐
3. Does the person have a drug, alcohol or other addiction? Yes ☐ No ☐

If yes, is the person willing to address this addiction? Yes ☐ No ☐

4. Does the applicant have a Key Worker at Mental Health Services? Yes ☐ No ☐
5. Are there any known risk indicators? Yes ☐ No ☐

If yes, please specify: ______________________________

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Referrer Details

Name of person making the referral: ______________________________

Name of Organisation/Program: ______________________________

Phone: ______________________ Mobile: ______________________

Address: ______________________________

Email: ______________________________

Referral to PHaMs

Participant Details

Name: ______________________ Date of Birth: ______________ Gender: M: ☐ F: ☐

Phone: ______________________ Mobile: ______________

Address: ____

Suburb: ______________________ Postcode: ______________

Cultural background: ______________________________

Interpreter Required: Yes ☐ No ☐ If so what language/dialect: ______________

Is the applicant aware of the referral? Yes ☐ No ☐

Alternative Contact for Participant: (as nominated by Participant)

Name: ______________________ Relationship to Participant: ______________

Phone: ______________________ Mobile: ______________________

This contact will be used if we have been unable to contact participant directly.

Reason for Referral:

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Please sign if you agree to the referral to PHaMs and to the exchange of information with the PHaMs team regarding the referral and participation in the PHaMs program.

Participant Signature: ______________________ Referrer Signature: ______________________

Name: ______________________ Name: ______________________

Date: ______________________ Date: ______________________

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