OUT DOORS Referral for Information Session

Thank you for your interest in Out Doors and our exciting programs! Please complete the following referral details in order for us to ascertain your eligibility and invite you to an upcoming information session. Completed forms can be posted or faxed to:

Out Doors Inc.
231 Napier Street
FITZROY VIC 3065
Fax: 9417 2163

If you have any queries regarding this referral contact the Intake and Assessment Worker at Out Doors on (03) 9417 2111.

Personal Details

Date of Referral _____

First Name _____ **Surname** _____

Preferred Name _____ **Gender** _____

Address _____

Suburb _____ **Post Code** _____

Home Number _____ **Mobile Number** _____

Email _____

Eligibility

☐ **Category 1: Aged between 16 years to 65, have an experience of mental illness, live in the north or east metropolitan regions of Melbourne and have an informal carer**

Date of birth \ \ **Age** _____

Mental Illness _____

Carer First Name _____ **Carer Surname** _____

Carer Address _____

Suburb _____ **Postcode** _____

Phone _____ **Mobile** _____

☐ **Category 2: Aged over 65 and at risk of mental illness (through isolation, illness, loss etc.), live in the north or west metropolitan regions of Melbourne.**

Date of birth \ \ **Age** _____

Optional

In the interests of providing more targeted services Out Doors would appreciate the following information about you, however this information is optional.

Country of Birth _____

Main Language Spoken at Home _____

Aboriginal ☐ **Torres Strait Islander** ☐ **Both** ☐ **Neither** ☐

Have you ever served in the Australian Defence Forces? Yes ☐ **No** ☐

How did you hear about us?

1. Friend, family or significant other ☐
2. GP/psychiatrist or medical practitioner ☐
3. Internet, website or social media ☐
4. Community health or allied health service ☐
5. Specialist mental health service (Community Mental Health Service) ☐
6. Community-based mental health service (Personal support and day programs) ☐
7. Other community-based service ☐
8. Supported accommodation/rehabilitation facility ☐
9. Government delivered service ☐
10. Hospital (public) ☐
11. Hospital (private) ☐
12. Other, please specify: ☐
13. Self ☐

Supportive person (if relevant)

First Name _____ **Surname** _____

Relationship to you _____ **(Agency)** _____

Address _____ **Email** _____

Suburb _____ **Postcode** _____

Phone: Contact Number _____ **Fax** _____ **Mobile** _____

Consent

I give permission for Out Doors to contact the supportive person listed above in relation to this referral and any invitation to attend Out Doors' programs.

YES ☐ **NO, contact me directly** ☐

Signed _____ **Date** _____

Name _____