

**MENTAL ILLNESS FELLOWSHIP
OF QUEENSLAND**

REFERRAL FORM - PHaMs
TO BE COMPLETED BY REFERRING
AGENT



Personal Helpers
& Mentors Program

An Australian Government Initiative

Number

PERSONAL INFORMATION

NAME: _____ D.O.B _____

CURRENT ADDRESS: _____

_____ POSTCODE: _____

TELEPHONE: _____ MOBILE _____ GENDER M / F

DIAGNOSIS: _____

MEDICATION: _____

CENTRELINK BENEFIT: YES / NO

TYPE OF BENEFIT: _____

HOW WOULD YOU LIKE US TO HELP YOU LIVE MORE INDEPENDENTLY
IN THE COMMUNITY? _____

APPLICANTS SIGNATURE: _____

REFERRAL SOURCE

REFERRER: NAME: _____ POSITION: _____

AGENCY NAME: _____

TELEPHONE: _____ MOBILE: _____

COMMENTS: _____

CASE MANAGER: YES / NO

HAS THE APPLICANT APPLIED FOR ANY OTHER SERVICES WITHIN THE
FELLOWSHIP: YES / NO _____