Early Intervention Recovery Program
Participant Application Form

Mental Illness Fellowship of WA
PO Box 1947
Midland DC, WA, 6936
Tel: 9237 8900
Web: www.mifwa.org.au

Referral Date:

Please Complete All Sections
Please complete all details with Participant (please print). Post or E mail to the address above or to teameirp@mifwa.org.au

Personal Details		
Surname:	First Name:	Date of Birth:
Contact Numbers:	Address Including Postcode:	
Aboriginal or Torres Straight Inslander: Yes No CALD: Yes No Country of Origin:		Sex: Male Female

Emergency Contacts		
Name:	Relationship:	Contact No:
Name:	Relationship:	Contact No:

Details of Mental Health Care Professional Involved		
Name:	Hospital/ Clinic:	Contact No:
Primary and Secondary Diagnosis:		
Is the Early Episode Related To A Drug Induced Psychosis? If Yes, Please Give Details:		
Current Medications and Side Effects:		
Is the Participant Involved With Any Other Health Care Professionals/ Services? (e.g GP, Headspace)		

Background Information
Purpose of Referral:
Expectations of The Program- What Would You/ The Participant Like To Achieve?
Are There Any Specific Triggers Which Cause You/ The Participant To Get Stressed and/ or Upset?
Is There Any Other Information That Will Help Us Understand How We Can Assist You With Your Program?

Have You/ The Participant Had Any Previous Experiences With Any Of The Following:

Substance Abuse: Yes No Comments:

Self Harm: Yes No Comments:

Violence/ Aggression: Yes No Comments:

Do You Have Any Medical Alerts (e.g. Epilepsy, Diabetes, Hep C etc):

EIRP Support Services	
What Type Of Support Would You/ The Participant Benefit From The Most? (Tick All Relevant Areas)	
Psychosocial Support	Health & Recreation
Managing A Budget	Fitness
Managing Accomodation	Stress Management & Relaxation
Independent Living Skills	Walking Groups
Identifying & Using Community Facilities	Social Outings
Employment/ Educational Support	Sporting & Recreation Programs
	Arts/ Craft Activities/ Hobbies
Others- Please Specify:	

Other General Comments (Level of Insight, Concentration, Motivation etc)

Referral Completed By:		
Name:	Title, Qualification:	Clinic/ Hospital and Postal Address:
Contact Number:	E mail:	Self Referral/ Referrer Signature:

Following acceptance of this referral, a comprehensive Needs Assessment will be arranged to ascertain suitability for the program.