BRIEF RISK ASSESSMENT FORM

RESIDENTIAL REFERRAL

Richmond Wellbeing

PATIENT DETAILS

Surname | Forenames

UMRN | Gender | Birthdate

Patient's address

Source of Information

☐ Previous clinical records ☐ Assessing clinician's knowledge of consumer's past behaviour/current clinical presentation

☐ Medical practitioner ☐ Police/ambulance/other agencies ☐ Other *(please specify)*

Suicidality

Static (historical) risk factors	Yes (1)	No (0)	Not Known	**Dynamic (current) risk factor**	Yes (2)	No (0)	Not Known
Previous attempt(s) on own life				Expressing suicidal ideas			
Previous serious attempt				Has plan/intent			
Family history of suicide				Expresses high level of distress			
Major psychiatric diagnosis				Hopelessness/perceived loss of coping or control over life			
Major physical disability/illness				Recent significant life event			
Separated/Widowed/Divorced				Reduced ability to control self			
Loss of job/retired				Current misuse of drugs/alcohol			
Protective Factors ***(describe)***							
Level of suicide risk (total score)			LOW (<7)	MODERATE (7-14)		HIGH (>14)	

Aggression/Violence

Static (historical) risk factors	Yes (1)	No (0)	Not Known	**Dynamic (current) risk factor**	Yes (1)	No (0)	Not Known
Recent incidents of violence				Expressing intent to harm others			
Previous use of weapons				Access to available means			
Male				Paranoid ideation about others			
Under 35 years old				Violent command hallucinations			
Criminal history				Anger, frustration or agitation			
Previous dangerous acts				Preoccupation with violent ideas			
Childhood abuse				Inappropriate sexual behaviour			
Role instability				Reduced ability to control self			
History of drug/alcohol misuse				Current misuse of drugs/alcohol			
Protective Factors ***(describe)***							
Level of Aggression/Violence (total score)			LOW (<7)	MODERATE (7-14)		HIGH (>14)	

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Other Risks Identified (and Risk Factors)

Risk Management Issues (please ensure alerts are noted here)

TO BE COMPLETED BY ASSESSING CLINICIAN

Full name | Signature | Date

Organisation/Facility | Position held

Address | Phone

(Where appropriate, management plan to be acknowledged by requesting medical practitioner)

Full name | Designation | Signature | Date

Richmond Wellbeing Inc.

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Please complete form and return to Richmond Wellbeing

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