Richmond Wellbeing

NGULLA MIA REFERRAL FORM

RESIDENTIAL ACCOMMODATION SERVICES

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Ngulla Mia (Noongar for "Our Place") is located in central Perth. Our Ngulla Mia service is for people experiencing mental health issues who are homeless or at risk of being homeless. This service has capacity to support 32 adults. People can stay for up to 12 months to work with the support of a RW Keyworker, to work intensively on their recovery toward building a meaningful life beyond crisis and distress. The team work according to recovery enabling, person driven practice principles, providing psychosocial support to enable personal recovery. Applications are reviewed by a panel consisting of our staff, a consumer representative, and staff from the City Mental Health Services. People using this service are required to have the support of a mental health case worker. Our service is staffed 24hrs per day 7 days a week.

More information on this service is available on our website www.rw.org.au. If you require assistance in selecting the right service, please contact our Intake Officer at intake@rw.org.au or 1800 742 466. * To be eligible for Richmond Wellbeing accommodation services, the applicant must be between 18 and 65 years of age.

Before submitting the referral, please ensure each box below has been addressed.

Have you and the applicant (tick if task is complete):

☐ Visited Ngulla Mia (by appointment) and discussed expectations and support needs

Please refer to the following checklist to ensure your referral is complete and all relevant information is attached, your referral must include:

- Primary Diagnosis of Mental Health Disorder
- Brief Risk Assessment completed by a clinician
- Current Client Management Plan
- Current Mental Health Treatment/Care Plan
- Recent Discharge Summaries
- Details of Forensic History *(if relevant)*
- Any current Community Treatment Order (CTO)
- Medication regime
- NDIS plan *(if applicable)*
- ☐ Physical Health Assessment completed by a GP or attending Doctor

A referral will be deemed incomplete until we have received all of this information.

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REFERRER DETAILS

Name | Agency/Position

Postal Address | Postcode

Phone | Email

How did you hear about us?

- ◯ Website
- ◯ Friend/Family/Another Client
- ◯ Flyer
- ◯ Social Media
- ◯ Radio
- ◯ Advertising
- ◯ Event
- ◯ Google
- ◯ Other

APPLICANT TO COMPLETE

First Name | Family Name

Preferred Name | Date of Birth

Address | Postcode

Phone | Mobile | Email

Gender:

- ◯ Female
- ◯ Transgender Male (FTM)
- ◯ Transgender Female (MTF)
- ◯ Non Binary
- ◯ Male
- ◯ Self describe
- ◯ Prefer not to disclose
- ◯ Different Identity (please describe)

Sexuality:

- ◯ Straight/Heterosexual
- ◯ Prefer not to disclose
- ◯ Lesbian/Gay/Homosexual
- ◯ Bisexual
- ◯ Unsure
- ◯ Self describe

Intersex Status:

- ◯ Yes
- ◯ Unsure
- ◯ No
- ◯ Prefer not to disclose

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APPLICANT TO COMPLETE

Pronouns:
- ◯ They/Them/Theirs
- ◯ She/Her/Hers
- ◯ He/ Him/His
- ◯ My Name/None
- ◯ Other

Relationship Status:
- ◯ Single
- ◯ Married
- ◯ Separated
- ◯ Self describe
- ◯ Divorced
- ◯ Widowed
- ◯ Defacto

Aboriginal ◯ Yes ◯ No Torres Straight origin ◯ Yes ◯ No Ethnicity

Country of Birth Culturally & Linguistically Diverse ◯ Yes ◯ No

Main Language spoken ◯ English ◯ Other Other

Interpreter required ◯ Yes ◯ No Children ◯ Yes ◯ No Visa status

Occupation

Source of income:
- ☐ Age Pension
- ☐ Carer Allowance
- ☐ Disability Pension Department
- ☐ of Veteran's Affairs
- ☐ Unemployment (Newstart)
- ☐ Youth Allowance
- ☐ Paid Work
- ☐ Other

Current accommodation (tick all that apply):
- ☐ Privately owned
- ☐ Short term/crisis
- ☐ Hospital
- ☐ Hostel
- ☐ Friends
- ☐ Homeless
- ☐ Rental
- ☐ Homeswest
- ☐ Family
- ☐ Other

Hold a DVA Card? ◯ Yes ◯ No

If yes, what type? ◯ Gold ◯ White ◯ Other

Centrelink number Expiry

Medicare number Expiry

Private health cover: ◯ Yes ◯ No Provider Member ID

Ambulance Cover: ◯ Yes ◯ No

Does someone else manage your money? ◯ Yes ◯ No Address

If yes, who (e.g. Public Trustee, include TM) Phone Mobile

Are you currently receiving services from another program within RIchmond Wellbieng? ◯ Yes ◯ No

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CONTACTS

Nominated support person (Next of kin / Alternative contact)

Name | Phone | Mobile

Email | Relationship

Do you have a case manager?

◯ Yes ◯ No Name | Organisation

Phone | Mobile | Email

Do you have a guardian appointed?

◯ Yes ◯ No Name

Phone | Mobile | Email

Do you have a public trustee?

◯ Yes ◯ No

Name | Phone | Mobile

Email

Do you have a GP?

◯ Yes ◯ No Name

Phone | Mobile | Email

Do you have a Chemist/Pharmacy?

◯ Yes ◯ No Name

Phone | Mobile | Email

Do you have a Psychologist?

◯ Yes ◯ No Name

Phone | Mobile | Email

Which of the above is your preferred contact?

◯ Support Person ◯ Case Manager ◯ Guardian Appointed ◯ Public Trustee ◯ GP

◯ Chemist/Pharmacy ◯ Psychologist

Preferred method of contact?

◯ Text ◯ Phone call ◯ Email ◯ Mail

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HEALTH AND WELLBEING

Please attach a Physical Health Assessment form

Existing NDIS Plan? ◯ Yes ◯ No

Formal mental health diagnosis? ◯ Yes ◯ No
If yes, please provide details

Drug and Alcohol Use

Provide details where appropriate.

Drug type	History of use	Current use
Alcohol		
T.H.C. (Cannabis)		
Benzodiazapines		
Opioids		
Stimulants ☐ Amphetamines ☐ Dexamphetamines A		
Other ☐ Hallucinogens ☐ MDMA - Ecstasy ☐ Prescription Drugs ☐ Solvents		
Cigarettes		

Any associated risk behaviours or problems:

(Injecting, overdoses, Hepatitis status)

While I am a resident, if I am considered to be using drugs and alcohol which is impacting on my recovery, I agree to work with an appropriate Drug and Alcohol Service.*

☐ Agree

SUPPORT AND AREAS OF NEED

Family Support Person
How involved is your family in your treatment? Include positive and negative influences.

Social Network
Who are your key support people?

Support Services
Are there any support services that you are involved with? If so, please describe their role/how they help you.

Typical Day
What time do you get up, what hobbies/interests do you have, do you attend social outings or structured day activities?

What transportation do you use? (tick all that apply)

- ☐ Drive own car
- ☐ Ride a bike
- ☐ Prefer to walk
- ☐ Use taxis
- ☐ Access public transport with prompting or support
- ☐ Access public transport independently
- ☐ Require transport assistance
- ☐ Others: *(please specify)*

SUPPORT AND AREAS OF NEED

Daily Living

Identify the level of support required and make a comment for each.

Personal Care

- [ ] Independent
- [ ] Require verbal prompt
- [ ] Require physical assistance

Comments

Diet

- [ ] Independent
- [ ] Require verbal prompt
- [ ] Require physical assistance

Comments

Home Care

- [ ] Independent
- [ ] Require verbal prompt
- [ ] Require physical assistance

Comments

Shopping

- [ ] Independent
- [ ] Require verbal prompt
- [ ] Require physical assistance

Comments

Leisure Interests

- [ ] Independent
- [ ] Require some support
- [ ] Require individual support

Comments

Finances/Employment

- [ ] Independent
- [ ] Require some support
- [ ] Finances managed on my behalf

Comments

Mobility

- [ ] Independent
- [ ] Require physical assistance
- [ ] Unsteady gait/history of falls

Comments

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MENTAL AND PHYSICAL HEALTH

Medical Conditions

Do you have any physical/health issues or disabilities (tick all that apply and provide details below):

Diabetes	☐ Yes	☐ No		Podiatry	☐ Yes	☐ No	
Bruise or bleed easily	☐ Yes	☐ No		Dental	☐ Yes	☐ No	
Heart complaints	☐ Yes	☐ No		Ulcerations	☐ Yes	☐ No	
Liver disease	☐ Yes	☐ No		Asthma	☐ Yes	☐ No	
Epilepsy	☐ Yes	☐ No		Allergies	☐ Yes	☐ No	
HIV/AIDS	☐ Yes	☐ No		Allergic to medication	☐ Yes	☐ No	
Blood pressure	☐ Yes	☐ No		Acquired head injury	☐ Yes	☐ No	
Speech	☐ Yes	☐ No		Thyroid problems	☐ Yes	☐ No	
Visual	☐ Yes	☐ No		Eating disorders	☐ Yes	☐ No	
Hearing	☐ Yes	☐ No		Substance abuse	☐ Yes	☐ No	
Mobility impairments	☐ Yes	☐ No		Women's health screens	☐ Yes	☐ No	
Respiratory disease	☐ Yes	☐ No		Men's health screens	☐ Yes	☐ No	
Intersex variation	☐ Yes	☐ No		Transgender health screens	☐ Yes	☐ No	
Other *(please state)*	☐ Yes	☐ No					

If yes, please provide details. Include the impact on your life and relating support needs.

Do you have any mobility aids? ☐ Yes ☐ No

If yes, please provide details.

STRESSFUL AND UNWELL TIMES

Do you know when you are becoming unwell?
Provide any warning signs you know of

What are your coping strategies in stressful times?
Provide details

Medication
How do you feel about taking medication?

Do you take regular medication? *(Please attach your medication regime)*

◯ Yes ◯ No

Do you require support taking your medication?

◯ Yes ◯ No

Do you use a Webster pack?

◯ Yes ◯ No

Any hospital admissions in the last 12 months?

Provide full details:

HISTORY

Forensic History

Legal Issues

Do you have any past or current legal issues, provide details:

COMMENTS

Additional Comments

Is there anything else you would like to add?

Aims and Outcomes

What would you like to achieve in partnership with the staff at Ngulla Mia?

- ☐ Find work/volunteer opportunities
- ☐ Look after my physical health more
- ☐ Make new friends/relationships
- ☐ Gain stable accommodation
- ☐ Work towards my recovery
- ☐ Join a local sporting clubs/gym
- ☐ Look at money management
- ☐ Further my education
- ☐ Develop homecare skills
- ☐ Other *(provide details below)*

DIAGNOSIS (TO BE COMPLETED BY REFERRER)

Diagnosis:

Treating Psychiatrist or previous Psychiatrist/s

History of needs, signs and symptoms

Current mental health presentation

Why is this applicant suitable for Ngulla Mia?

Key areas in which this applicant would benefit from support

- ☐ Homecare skills
- ☐ Improving personal care
- ☐ Community integration/linkages
- ☐ Development of day structure/activities
- ☐ Improving or maintaining mental health
- ☐ Improving or maintaining physical health
- ☐ Managing medications
- ☐ Symptom management/relapse prevention

Are there any compliance difficulties with treatment?

◯ Yes ◯ No

If YES, please describe

Is the applicant on a Community Treatment Order?

◯ Yes ◯ No Expiry date ☐ Copy attached

DIAGNOSIS (TO BE COMPLETED BY REFERRER)

Comments/additional information to assist this referral

CONSENT TO RELEASE INFORMATION

Full name *DOB*

I , authorise Richmond Wellbeing to release information to and communicate with the people/organisations listed below, and/or for these people/organisations to release information to and communicate with Richmond Wellbeing.

I understand that the information will only be shared between Richmond Wellbeing and the people/organisations listed below for the purpose of supporting or assisting my referral, placement and/or recovery at Ngulla Mia.

I am aware that any alterations to this form are only made with my consent, which would be indicated by my initials, signature and date of the alteration(s).

Western Australian Area Health Services - Mental Health
(NMAHS-MH, SMAHS-MH, WACHS-MH)

General Practitioners

Parents/Advocate/Guardian/Carer

Others

Signature *Date*

DECLARATIONS

Declaration by Applicant/Guardian

I declare the information in this application is true and correct. *

Name

Date

*Signature**

Declaration by Referrer

I declare that all information in this referral has been checked and is correct. *

Name

Date

*Signature**

Please complete form and return to Richmond Wellbeing

F: (08) 9258 3090

E: intake@rw.org.au