RESIDENTIAL ACCOMMODATION SERVICES

Bassendean
This is a community based, home-like environment that offers long-term accommodation. Bassendean is a recovery focused program for people with severe and persistent mental ill health requiring a high level of support. The expectation is that residents will progress to more independent living arrangements. Support staff are available on site at all times.

Accommodation consists of four separate villas on one campus. Each villa contains four bedrooms. The villas may consist of both male and female residents.

Bunbury & Busselton
This initiative offers long-term accommodation with a recovery focus to make the transition into independent living within the community. Support staff are available on site at all times.

*To be eligible for this service, the applicant must reside in the South West region.

Carer Respite
This service is based at our Westminster residential service and provides accommodation for a person being cared for by a recognised Carer. This service allows the Carer to have some reprieve in times of need, as Richmond Wellbeing will provide the care and support required for the care recipient.

Kelmscott
Kelmscott provides a long term residential supported accommodation service. This service provides support staff 24 hours a day, seven days a week. Each resident has their own key worker who will partner with him or her to develop a plan assisting their personal recovery.

PaRK Service (Peel, Rockingham and Kwinana)
PaRK is a community based service for individuals with a diagnosis of severe and persistent mental ill health requiring ongoing clinical support. Residents will be able to access the shared accommodation on offer for up to one year. There is the option of continued outreach support for a further three months once exiting the service.

Westminster
Westminster provides short term residential support for those experiencing a social crisis. This residential service provides support needs for those who have severe and persistent mental ill health. Extended day support is provided with a recovery focused program seven day per week. This accommodation service is available for up to three months.

More information on each of these services 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.
REFERRER DETAILS

Name: ___________________________ Agency / Position: ___________________________
Postal Address: ___________________________ Postcode: ___________________________
Phone: ___________________________ Email: ___________________________

SUPPORTING DOCUMENTS CHECKLIST

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 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)

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

APPLICANT TO COMPLETE

1. Your Details

First Name: ___________________________ Family Name: ___________________________
Preferred Name: ___________________________
Gender: ☐ Male ☐ Female ☐ LGBTIQ+ ☐ Other Date of Birth: ___________________________
Address: ___________________________ Postcode: ___________________________
Phone: ___________________________ Mobile: ___________________________ Email: ___________________________
Aboriginal: ☐ Yes ☐ No Torres Strait origin: ☐ Yes ☐ No
Culturally and Linguistically Diverse: ☐ Yes ☐ No Country of Birth: ___________________________
Main Language spoken: ☐ English ☐ Other: ___________________________
Interpreter required: ☐ Yes ☐ No Visa Status: ___________________________
Living Situation: ☐ Living Independently ☐ Living with family member/carer
☐ Homeless ☐ Other: ___________________________
Marital Status: ☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Widowed ☐ Defacto
Children: ☐ Yes ☐ No Occupation: ___________________________
**RESIDENTIAL REFERRAL FORM**

Source of Income:  
- Age Pension  
- Carer Allowance  
- Disability Pension  
- Department of Veteran’s Affairs  
- Family Assistance  
- Unemployment  
- Youth Allowance  
- Paid work  
- Other (please specify):  

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:  

2. Service Referral  
Which service would you like to be referred to?  
- Bassendean  
- Bunbury  
- Busselton  
- Carer Respite  
- Westminster  
- Kelmscott  
- PaRK  

3. Contacts  
**Nominated support person (Next of kin / Alternative contact)**  
Name:  
Relationship:  
Email:  
Phone:  
Mobile:  

Do you have a Case Manager?  
- Yes  
- No  
Name:  
Email:  
Phone:  
Mobile:  

Do you have a guardian?  
- Yes  
- No  
Name:  
Email:  
Phone:  
Mobile:  

Do you have a Public Trustee?  
- Yes  
- No  
Name:  
Email:  
Phone:  
Mobile:  

Do you have a GP?  
- Yes  
- No  
Name:  
Email:  
Phone:  
Mobile:  

Do you have a current support network?  
- Yes  
- No  
Name:  
Email:  
Phone:  
Mobile:  

Which of the above is your preferred contact?  
- Support Person  
- Case Manager  
- GP  
- Public Trustee  
- Support Network  

4. Mental Health  
Existing NDIS Plan?  
- Yes  
- No  
NDIS Plan Number:  

Formal mental health diagnosis?  
- Yes  
- No  
If yes, please specify.  

*Please note, to be eligible for Richmond Wellbeing Residential Accommodation services the applicant must have ongoing clinical support guaranteed by a public mental health service, a private Psychiatrist, or General Practitioner; or be willing to engage with one of the above mentioned services.*
5. Physical Health

**Physical Issues / Conditions**

Any health issues or existing health conditions? [ ] Yes  [ ] No

Are there any physical health issues you would like help with? [ ] Yes  [ ] No

Tick all that apply:

<table>
<thead>
<tr>
<th>Condition</th>
<th>[ ] Yes</th>
<th>[ ] No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bruise or bleed easily</td>
<td></td>
<td></td>
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<tr>
<td>Heart complaints</td>
<td></td>
<td></td>
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<tr>
<td>Liver disease</td>
<td></td>
<td></td>
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<tr>
<td>Epilepsy</td>
<td></td>
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<tr>
<td>HIV / AIDS</td>
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<tr>
<td>Hepatitis A, B or C</td>
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<tr>
<td>Blood pressure</td>
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<tr>
<td>Speech</td>
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<tr>
<td>Visual</td>
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<tr>
<td>Hearing</td>
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<tr>
<td>Mobility impairments</td>
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<tr>
<td>Respiratory disease</td>
<td></td>
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<tr>
<td>Podiatry</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Dental</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Ulcerations</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Asthma</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Allergies</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Allergic to medication</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Pregnant</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Acquired Head Injury</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Thyroid problems</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Women's Health screens</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Men's Health screens</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
</tbody>
</table>

If yes to any of the above, please provide details:

________________________________________________________________________

________________________________________________________________________

Do you have any impairments?  [ ] Vision  [ ] Hearing  [ ] Speech  [ ] Other (please specify): _________________________

If yes to any of the above, please provide details:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

*FORM CONTINUES PAGE 6*
### Drug and Alcohol Use

- **Drug Type**
- **History of Use**
- **Current Use & View of Use**

#### ALCOHOL

T.H.C. (CANNABIS)

BENZODIAZAPINES

OPIOIDS

STIMULANTS

- Box to check: Amphetamines
- Box to check: Dexamphetamines

OTHER

- Box to check: Hallucinogens
- Box to check: MDMA - Ecstasy
- Box to check: Prescription Drugs
- Box to check: Solvents
- Box to check: ____________

**Any Associated Risk Behaviours or Problems (injecting, overdoses, hepatitis status):**

---

**While I am a resident of Richmond Wellbeing’s Residential Accommodation, if I am considered to be using Drugs and Alcohol to misuse, I agree to work with an appropriate Drug and Alcohol Service**

**Medication**

- **How do you feel about taking medication?**

---

- **Do you require support taking your medication?**
  - Box to check: Yes
  - Box to check: No
- **Do you take regular medication?**
  - Box to check: Yes
  - Box to check: No  
  *(Attach your medication regime)*
- **Do you use a Webster pack?**
  - Box to check: Yes
  - Box to check: No
Any hospital admissions in the last 12 months?  ☐ Yes  ☐ No  Provide full details:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

6. History

Forensic History

________________________________________________________________________

Legal Issues

Do you have any past or current legal issues  ☐ Yes  ☐ No
Provide details:

________________________________________________________________________

7. Support Needs

How many days a week do you require support?  ________________
Are there any particular tasks you find challenging?

________________________________________________________________________

What support do you need? Tick all that apply:

☐ Getting in/out of bed  ☐ Laundry  ☐ Emotional support
☐ Bathing  ☐ Shopping  ☐ Engaging with social groups
☐ Dressing/Undressing  ☐ Gardening  ☐ Advocacy (someone to talk on your behalf)
☐ With continence  ☐ Cleaning  ☐ Information of services/support
☐ Toileting  ☐ Keeping safe  ☐ Social/Family contact
☐ Washing  ☐ To communicate  ☐ Psycho-education (e.g. stress management)
☐ Cooking  ☐ With documentation  ☐ Computer/IT skills
☐ Medication  ☐ Transport  ☐ Family Relationships
☐ Eating  ☐ Budgeting  ☐ Other (please specify):
☐ Accessing counselling / talking to someone  ☐ Accessing medical / health appointments
RESIDENTIAL REFERRAL FORM

Additional comments:

________________________________________________________________________

________________________________________________________________________

Emergency / Early Exit Plan
Have you thought of or made any arrangements in the event of an emergency? □ Yes □ No
Do you have alternative accommodation in the context of an unplanned event? □ Yes □ No
Can we confirm that you have alternative accommodation? □ Yes □ No
Please provide details:

________________________________________________________________________

________________________________________________________________________

8. Consent

I acknowledge the information provided is true and correct.
I agree that Richmond Wellbeing may contact my health service providers to gather additional information to assist with my referral if needed.
I consent to this referral being submitted for consideration of Richmond Wellbeing’s Residential Accommodation services.

Signature: ____________________________________________

Date: ________________________________________________

* If Guardian, provide a copy of your Guardian Order issued by the State Health Tribunal.
### Residential Referral

#### BRIEF RISK ASSESSMENT

**Name:**

**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**

<table>
<thead>
<tr>
<th>Static (historical) factors</th>
<th>Yes (1)</th>
<th>No (0)</th>
<th>Not Known</th>
<th>Dynamic (current) risk factor</th>
<th>Yes (2)</th>
<th>No (0)</th>
<th>Not Known</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous attempt(s) on own life</td>
<td></td>
<td></td>
<td></td>
<td>Expressing suicidal ideas</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Previous serious attempt</td>
<td></td>
<td></td>
<td></td>
<td>Has plan/intent</td>
<td></td>
<td></td>
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<tr>
<td>Family history of suicide</td>
<td></td>
<td></td>
<td></td>
<td>Expresses high level of distress</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Major psychiatric diagnosis</td>
<td></td>
<td></td>
<td></td>
<td>Hopelessness/perceived loss of coping or control over life</td>
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<tr>
<td>Major physical disability/illness</td>
<td></td>
<td></td>
<td></td>
<td>Recent significant life event</td>
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<tr>
<td>Separated/Widowed/Divorced</td>
<td></td>
<td></td>
<td></td>
<td>Reduced ability to control self</td>
<td></td>
<td></td>
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<tr>
<td>Loss of job/retired</td>
<td></td>
<td></td>
<td></td>
<td>Current misuse of drugs/alcohol</td>
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<td></td>
</tr>
</tbody>
</table>

**Protective Factors (describe):**

**Level of Suicide Risk (total score):**

- Low (<7)
- Moderate (7-14)
- High (>14)

**Aggression/Violence**

<table>
<thead>
<tr>
<th>Static (historical) factors</th>
<th>Yes (1)</th>
<th>No (0)</th>
<th>Not Known</th>
<th>Dynamic (current) risk factor</th>
<th>Yes (1)</th>
<th>No (0)</th>
<th>Not Known</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent incidents of violence</td>
<td></td>
<td></td>
<td></td>
<td>Expressing intent to harm others</td>
<td></td>
<td></td>
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<tr>
<td>Previous use of weapons</td>
<td></td>
<td></td>
<td></td>
<td>Access to available means</td>
<td></td>
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<tr>
<td>Male</td>
<td></td>
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<td>Paranoid ideation about others</td>
<td></td>
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<tr>
<td>Under 35 years old</td>
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<td></td>
<td></td>
<td>Violent command hallucinations</td>
<td></td>
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<tr>
<td>Criminal history</td>
<td></td>
<td></td>
<td></td>
<td>Anger, frustration or agitation</td>
<td></td>
<td></td>
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<tr>
<td>Previous dangerous acts</td>
<td></td>
<td></td>
<td></td>
<td>Preoccupation with violent ideas</td>
<td></td>
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<tr>
<td>Childhood abuse</td>
<td></td>
<td></td>
<td></td>
<td>Inappropriate sexual behaviour</td>
<td></td>
<td></td>
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<tr>
<td>Role instability</td>
<td></td>
<td></td>
<td></td>
<td>Reduced ability to control self</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>History of drug/alcohol misuse</td>
<td></td>
<td></td>
<td></td>
<td>Current misuse of drugs/alcohol</td>
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</tbody>
</table>

**Protective Factors (describe):**
Residential Referral

<table>
<thead>
<tr>
<th>LEVEL OF SUICIDE RISK (total score):</th>
<th>[☐] LOW (&lt;7)</th>
<th>[☐] MODERATE (7-14)</th>
<th>[☐] HIGH (&gt;14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OTHER RISKS IDENTIFIED (AND RISK FACTORS)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>RISK MANAGEMENT ISSUES (please ensure alerts are noted here)</td>
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<td></td>
<td></td>
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<tr>
<td>(To be completed by assessing clinician)</td>
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<td></td>
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</tr>
<tr>
<td>FULL NAME:</td>
<td>SIGNATURE:</td>
<td>DATE:</td>
<td></td>
</tr>
<tr>
<td>ORGANISATION/ FACILITY:</td>
<td>POSITION HELD:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADDRESS:</td>
<td>PHONE:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Where appropriate, management plan to be acknowledged by requesting medical practitioner)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FULL NAME:</td>
<td>DESIGNATION:</td>
<td>SIGNATURE:</td>
<td>DATE:</td>
</tr>
</tbody>
</table>

PLEASE COMPLETE THE FORM AND RETURN TO RICHMOND WELLBEING

F: (08) 9258 3090
E: intake@rw.org.au
P: PO Box 682, Bentley WA 6982

Richmond Wellbeing Inc.
ABN: 36 658 041 325
Charitable Collections Licence No: 20566
P: PO Box 682, Bentley WA 6982
T: 1800 742 466