



**Richmond  
Wellbeing**

# **NGULLA MIA REFERRAL FORM**

**RESIDENTIAL ACCOMMODATION SERVICE**

# NGULLA MIA REFERRAL FORM

**Please note**, admission to Ngulla Mia is determined by a selection panel consisting of three members. A current Mental Health Care/Treatment Plan and completed brief risk assessment must be included in your application submission.

## REFERRER DETAILS

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

*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 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.

If you have any questions regarding referrals to Ngulla Mia, please contact Richmond Wellbeing on 1800 742 466.

# NGULLA MIA REFERRAL FORM

## APPLICANT TO COMPLETE WITH THE REFERRER

### 1. Applicant Details

First Name:	Family Name:	Date of Birth:
Preferred Name:	Ethnicity:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> LGBTIQ+ <input type="checkbox"/> Other <input type="checkbox"/> Decline to answer		
Current Address:	Post Code:	
Phone:	Mobile:	Email:
Difficulty reading or writing: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Aboriginal: <input type="checkbox"/> Yes <input type="checkbox"/> No	Torres Strait origin: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Culturally and Linguistically Diverse: <input type="checkbox"/> Yes <input type="checkbox"/> No	Country of Birth: _____	
Main Language spoken: <input type="checkbox"/> English	<input type="checkbox"/> Other: _____	
Interpreter required: <input type="checkbox"/> Yes <input type="checkbox"/> No	Visa Status: _____	
Current Accommodation (Tick all that apply):		
<input type="checkbox"/> Privately owned	<input type="checkbox"/> Rental	<input type="checkbox"/> Family
<input type="checkbox"/> Homeless	<input type="checkbox"/> Hospital	<input type="checkbox"/> Hostel
<input type="checkbox"/> Short term / Crisis accommodation	<input type="checkbox"/> Homeswest	<input type="checkbox"/> Friends
<input type="checkbox"/> Other		
How long have you lived in current accommodations: _____		
If less than 3 months, where did you live previously:		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated		
<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> De facto		
Children: <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequency of contact: _____	Occupation: _____
Source of Income:	<input type="checkbox"/> Age Pension	<input type="checkbox"/> Carer Allowance
	<input type="checkbox"/> Disability Pension	<input type="checkbox"/> Department of Veteran's Affairs
	<input type="checkbox"/> Family Assistance	<input type="checkbox"/> Unemployment
	<input type="checkbox"/> Youth Allowance	<input type="checkbox"/> Paid work
	<input type="checkbox"/> Other (please specify): _____	
Hold a DVA Card? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what type? <input type="checkbox"/> Gold <input type="checkbox"/> White <input type="checkbox"/> Other	
Centrelink Number: _____	Expiry: _____	
Medicare Number: _____	Expiry: _____	
Private Health Cover: <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider: _____	
	Member ID: _____	
Existing NDIS Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	NDIS Plan Number: _____	(Attach plan)

# NGULLA MIA REFERRAL

Does someone else manage your money?  Yes  No

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

Address:

Phone No:

Mobile:

## 2. Contacts

### Nominated support person (Next of kin / Alternative contact)

Name:

Relationship:

Email:

Phone:

Mobile:

Address:

### Contact Person in Case of Emergency

Name:

Relationship:

Email:

Phone:

Mobile:

Address:

### General Practitioner:

Name:

Phone:

Address:

### Chemist / Pharmacy:

Name:

Phone:

Address:

Do you have a guardian?  Yes  No Name:

Email:

Phone:

Mobile:

Do you have a Case Manager?  Yes  No Name:

Email:

Phone:

Mobile:

Do you have a current support network?  Yes  No

Name:

Email:

Phone:

Mobile:

## 3. Support and Areas of Need

### Family support person

How involved is your family in your treatment? Include positive and negative influences:

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## Social Network

Who are your key support people?

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

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## Typical Day

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

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

- |  |   |
|--|---|
| <input type="checkbox"/> Drive own car                                     | <input type="checkbox"/> Ride a bike                  |
| <input type="checkbox"/> Access public transport independently             | <input type="checkbox"/> Require transport assistance |
| <input type="checkbox"/> Access public transport with prompting or support | <input type="checkbox"/> Use taxis                    |
| <input type="checkbox"/> Prefer to walk                                    | <input type="checkbox"/> Other: _____                 |

**Daily Living** – Identify the level of support required and make a comment for each.

PERSONAL CARE:

- Independent  Require verbal prompt  Require physical assistance

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# NGULLA MIA REFERRAL

## DIET:

Independent  Require verbal prompt  Require physical assistance

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## HOME CARE:

Independent  Require verbal prompt  Require physical assistance

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## SHOPPING:

Independent  Require verbal prompt  Require physical assistance

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## LEISURE INTERESTS:

Independent  Require some support  Require individual support

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## FINANCES / EMPLOYMENT:

Independent  Require some support  Finances managed on my behalf

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## MOBILITY:

Independent  Require physical assistance  Unsteady gait / history of falls

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## 4. Health & Wellbeing

### Do you have any physical/health issues or disabilities

Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Podiatry	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise or bleed easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart complaints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcerations	<input type="checkbox"/> Yes <input type="checkbox"/> No
Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV / AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergic to medication	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis A, B or C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Acquired Head Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No
Speech	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Visual	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eating Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Substance abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mobility impairments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Women's Health screens	<input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Men's Health screens	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

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### Drug and Alcohol Use – Provide details where appropriate

Drug Type                      History of Use                      Current Use & View of Use

ALCOHOL

T.H.C. (CANNABIS)

BENZODIAZAPINES

OPIOIDS

STIMULANTS

- Amphetamines
- Dexamphetamines

# NGULLA MIA REFERRAL

## OTHER

- Hallucinogens
- MDMA - Ecstasy
- Prescription Drugs
- Solvents
- \_\_\_\_\_

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

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While I am a resident of Ngulla Mia, if I am considered to be using Drugs and Alcohol to misuse, I agree to work with an appropriate Drug and Alcohol Service

## 5. Stressful & Unwell Times

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

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What are your coping strategies in stressful times? Provide details:

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## Medication

How do you feel about taking medication?

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Do you require support taking your medication?  Yes  No

Do you take regular medication?  Yes  No *(Attach your medication regime)*

Do you use a Webster pack?  Yes  No

Any hospital admissions in the last 12 months?  Yes  No Provide full details:

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## 6. History

### Forensic History

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### Legal Issues

Do you have any past or current legal issues Select...

Provide details:

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## 7. Comments

### Additional Comments

Is there anything else you would like to add:

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### Aims & Outcomes

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

- |  |                                 |
|--|---------------------------------|
| <input type="checkbox"/> Find work / volunteer opportunities | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Join a local sporting clubs / gym   |                                 |
| <input type="checkbox"/> Look after my physical health more  | <hr/>                           |
| <input type="checkbox"/> Look at money management            | <hr/>                           |
| <input type="checkbox"/> Make new friends / relationships    | <hr/>                           |
| <input type="checkbox"/> Further my education                | <hr/>                           |
| <input type="checkbox"/> Gain stable accommodation           | <hr/>                           |
| <input type="checkbox"/> Develop homecare skills             | <hr/>                           |
| <input type="checkbox"/> Work towards my recovery            |                                 |

FORM CONTINUES PAGE 10

# NGULLA MIA REFERRAL

## THIS SECTION IS TO BE COMPLETED BY THE REFERRER

Diagnosis:

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Treating Psychiatrist or previous Psychiatrist/s:

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History of needs, signs and symptoms:

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Current mental health presentation:

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Why is this Applicant suitable for Ngulla Mia:

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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:

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Is the Applicant on a Community Treatment Order:  Yes  No

Expiry Date: \_\_\_\_\_ (attach copy)



# NGULLA MIA REFERRAL

## NGULLA MIA - CONSENT TO RELEASE INFORMATION

I \_\_\_\_\_, (DOB) \_\_\_\_\_ 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:

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Parents / Advocate / Guardian / Carer:

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Others:

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Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Witness: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## DECLARATIONS

### Declaration by Applicant / Guardian

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

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### Declaration by Referrer

I declare that all information in this referral has been checked and is correct, as of date \_\_\_\_\_.

Name: \_\_\_\_\_


Signature: \_\_\_\_\_

Date: \_\_\_\_\_



PLEASE COMPLETE  
FORM & RETURN TO  
RICHMOND  
WELLBEING  
F (08) 9258 3090  
E [intake@rw.org.au](mailto:intake@rw.org.au)

# Ngulla Mia Referral

 <b>BRIEF RISK ASSESSMENT</b>		SURNAME:		UMRN:	SEX:				
		FORENAMES:		BIRTHDATE:					
		PATIENT'S ADDRESS:							
<b>SOURCE OF INFORMATION</b>		<input type="checkbox"/> Previous clinical records		<input type="checkbox"/> Assessing clinician's knowledge of consumer's past behaviour/current clinical presentation					
<input type="checkbox"/> Medical Practitioner	<input type="checkbox"/> Police/ambulance/other agencies	<input type="checkbox"/> Other (please specify) _____							
<b>SUICIDALITY</b>		Yes	No	Not	<b>Dynamic (current) risk factor</b>		Yes	No	Not
<b>Static (historical) factors</b>		(1)	(0)	Known			(2)	(0)	Known
Previous attempt(s) on own life		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Expressing suicidal ideas		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous serious attempt		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has plan/intent		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family history of suicide		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Expresses high level of distress		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Major psychiatric diagnosis		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hopelessness/perceived loss of coping or control over life		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Major physical disability/illness		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recent significant life event		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Separated/Widowed/Divorced		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reduced ability to control self		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of job/retired		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Current misuse of drugs/alcohol		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>PROTECTIVE FACTORS</b> (describe) :									
<b>LEVEL OF SUICIDE RISK (total score):</b> <input type="checkbox"/> <b>LOW (&lt;7)</b> <input type="checkbox"/> <b>MODERATE (7-14)</b> <input type="checkbox"/> <b>HIGH (&gt;14)</b>									
<b>AGGRESSION/VIOLENCE</b>		Yes	No	Not	<b>Dynamic (current) risk factor</b>		Yes	No	Not
<b>Static (historical) factors</b>		(1)	(0)	Known			(1)	(0)	Known
Recent incidents of violence		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Expressing intent to harm others		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous use of weapons		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Access to available means		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Male		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paranoid ideation about others		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Under 35 years old		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Violent command hallucinations		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Criminal history		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anger, frustration or agitation		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous dangerous acts		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Preoccupation with violent ideas		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Childhood abuse		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inappropriate sexual behaviour		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Role instability		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reduced ability to control self		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of drug/alcohol misuse		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Current misuse of drugs/alcohol		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>PROTECTIVE FACTORS</b> (describe) :									

**BRIEF RISK ASSESSMENT**

# Ngulla Mia Referral



<b>LEVEL OF SUICIDE RISK (total score):</b> <input type="checkbox"/> <b>LOW (&lt;7)</b> <input type="checkbox"/> <b>MODERATE (7-14)</b> <input type="checkbox"/> <b>HIGH (&gt;14)</b>			
<b>OTHER RISKS IDENTIFIED (AND RISK FACTORS)</b>			
<b>RISK MANAGEMENT ISSUES</b> (please ensure alerts are noted here)			
<small>(To be completed by assessing clinician)</small>			
<b>FULL NAME:</b>		<b>SIGNATURE:</b>	<b>DATE:</b>
<b>ORGANISATION/ FACILITY:</b>		<b>POSITION HELD:</b>	
<b>ADDRESS:</b>		<b>PHONE:</b>	
<small>(Where appropriate, management plan to be acknowledged by requesting medical practitioner)</small>			
<b>FULL NAME:</b>	<b>DESIGNATION:</b>	<b>SIGNATURE:</b>	<b>DATE:</b>

**PLEASE COMPLETE THE FORM AND RETURN TO RICHMOND WELLBEING**

F: (08) 9258 3090  
 E: [intake@rw.org.au](mailto: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



# NGULLA MIA REFERRAL FORM

## NGULLA MIA ELIGIBILITY

To be eligible for the program, applicants must meet all of the following criteria:

1. Men or women aged between 18 - 65 years
2. Have signs and symptoms of a serious and persistent mental illness (*see Appendix 1*)
3. Be case managed by Community Mental Health Service, private psychiatrist or GP
4. Are homeless or at risk of homelessness (*see Appendix 2*)
5. Are experiencing difficulty accessing and engaging with appropriate services, exacerbated by homelessness. This might include repeated admission and discharge from hospitals and other support service
6. Require medium level support of between 4 - 6 hours of direct support per day.
7. The applicant expresses a commitment and willingness to participate in the program

*NOTE: This facility is unable to accommodate residents with accompanying children*



## APPENDIX

### Appendix 1.0

#### DEFINITION OF SEVERE AND PERSISTENT MENTAL ILLNESS

Based on the service level agreement (30/09/2012), in order to be assessed as having a mental illness that is serious and persistent, the following conditions need to apply.

The presence of one of the following diagnoses:

- Chronic or recurrent psychosis (such as schizophrenia, other psychotic disorders)
- Organic brain disorder associated with significant psychiatric features (such as some chronic sequela associated with brain injury and some medical conditions, e.g. Huntington's Disease)
- Chronic non-psychotic disorders that may result in functional impairment (such as Obsessive Compulsive Disorder, bi-polar disorders, depressive disorders, personality disorders which result in functional impairment, self-injury, significant behavioural problems)
- Severe and chronic impairment of daily life activities

To confirm the seriousness and persistence, a person must demonstrate:

- A level of functional impairment that is associated with having a diagnosed mental illness that interferes with the person's ability to live independently to the extent that they;
- Require support with the activities of daily life, and/or
- Support is not available and the essential activity does not occur, and
- Their level of impairment is long term and not the result of a short-term acute episode

The function of the diagnosis, as it relates to determining "serious and persistent", is to determine the type, duration and severity of the impairment and the existence of risk factors, which may exacerbate the person's condition.

Such risk factors include:

- Existence of co-morbidity (intellectual, physical and/or substance abuse)
- Lack of effective environmental support
- Lack of functional social networks (social isolation)
- Unstable accommodation

An evidenced based assessment is required to confirm "serious and persistent". This includes assessment to determine:

- Psychiatric diagnosis
- Intellectual capacity
- Medical status
- Evidence of psychosocial risk factors that are highly correlated with severe daily functional impairment
- Medical status

## NGULLA MIA REFERRAL FORM

- Evidence of psychosocial risk factors that are highly correlated with severe daily functional impairment

As well, the person's impairment must have been in existence for over six months. During the past two years the person is likely to have had one or more admissions to an acute facility, particularly if there is inadequate life support given their level of functional impairment.

## Appendix 2.0

### DEFINITION OF HOMELESSNESS

Based on the service level agreement (30/09/2012), a person is defined as being homeless when they do not have adequate access to safe and secure housing. These people may be further classified as suffering:

1. Primary homelessness or sleeping rough or without conventional accommodation, such as:
  - a. People living on the streets or in parks
  - b. Squatting in vacant buildings
  - c. Using cars or makeshift dwellings
  
2. Secondary homelessness or stop gap accommodation:
  - a. People who move frequently from one form of transitional shelter to another. This group includes people using emergency accommodation, such as hostels for the homeless or night shelters
  - b. Young people staying in youth refuges
  - c. Women and children escaping relationship and family violence, staying in women's refuges and alternative support accommodation options
  - d. Families residing in externally supported accommodation options and people residing temporarily with other families, acquaintances and friends because they have no accommodation of their own
  
3. Tertiary homelessness or insecure tenure / marginally housed:
  - a. People whose living arrangements do not provide them with security of tenure as provided by a lease or who are living in accommodation that is unsafe or harmful to their health. Such accommodation might include some boarding houses, caravan parks, rooming houses or special accommodation houses
  - b. It is also recognised that some people actively make a lifestyle choice to reside in boarding houses, rooming houses and caravan parks and should not be considered as either homeless or marginally housed

**Richmond Wellbeing**

PO Box 682, Bentley, WA 6982

T (08) 1800 742 466

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