



**Richmond
Wellbeing**

RECOVERY HOUSE REFERRAL FORM

RESIDENTIAL ACCOMMODATION SERVICE

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RECOVERY HOUSE PROGRAM

Located in Queens Park, Recovery House offers an intensive six month recovery focused residential program, enabling participants to understand and master their experiences through personal development and self-discovery.

This is a community based program led by the participants – guided by our skilled staff. The participants live on site in the accommodation provided.

More information on the Recovery House 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.

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)
- Physical Health Assessment completed by a GP or attending Doctor

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

PROGRAM INTAKE

The Recovery House program is offered twice a year, with services commencing in January and July.

Select which Intake Session you would like to participate in:

- January
- July

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APPLICANT TO COMPLETE

1. Your 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		
Address:		Postcode:
Phone:	Mobile:	Email:
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:
Living Situation: <input type="checkbox"/> Living Independently <input type="checkbox"/> Living with family member/carer <input type="checkbox"/> Homeless <input type="checkbox"/> Other:		
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"/> Defacto		
Children: <input type="checkbox"/> Yes <input type="checkbox"/> No		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:		

2. Contacts

Nominated support person (Next of kin / Alternative contact)

Name:	Relationship:	
Email:	Phone:	Mobile:
Do you have a Case Manager? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name:		
Email:	Phone:	Mobile:
Do you have a guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name:		
Email:	Phone:	Mobile:
Do you have a Public Trustee? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name:		
Email:	Phone:	Mobile:

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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

3. Mental Health

Existing NDIS Plan? Yes No NDIS Plan Number: _____ (Attach plan)

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.*

4. 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:

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

Do you have any impairments? Vision Hearing Speech

Other (please specify): _____

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

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

OTHER

- Hallucinogens
- MDMA - Ecstasy
- Prescription Drugs
- Solvents
- _____

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?

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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:

5. History

Forensic History

Legal Issues

Do you have any past or current legal issues? Yes No

Provide details:

6. 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:

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

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Describe what you hope to achieve at Recovery House:

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:

7. 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.*

PLEASE COMPLETE
FORM & RETURN TO
RICHMOND
WELLBEING

F (08) 9258 3090
E intake@rw.org.au

Residential Referral

 BRIEF RISK ASSESSMENT		SURNAME:		UMRN:	SEX:				
		FORENAMES:		BIRTHDATE:					
		PATIENT'S ADDRESS:							
SOURCE OF INFORMATION		<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) _____							
SUICIDALITY Static (historical) factors		Yes (1)	No (0)	Not Known	Dynamic (current) risk factor		Yes (2)	No (0)	Not 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"/>
PROTECTIVE FACTORS (describe) :									
LEVEL OF SUICIDE RISK (total score): <input type="checkbox"/> LOW (<7) <input type="checkbox"/> MODERATE (7-14) <input type="checkbox"/> HIGH (>14)									
AGGRESSION/VIOLENCE Static (historical) factors		Yes (1)	No (0)	Not Known	Dynamic (current) risk factor		Yes (1)	No (0)	Not 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"/>
PROTECTIVE FACTORS (describe) :									

BRIEF RISK ASSESSMENT

Residential Referral

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

**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.
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Richmond Wellbeing

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