Richmond Wellbeing
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# *Referral Form:*
# Living Recovery

Located in Helena Valley, **Living Recovery - Mental Health Empowerment Program** offers an intensive six-month program focused on 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 whilst they complete the program. Participants can receive up to 6 months post program support.

**Living Recovery** welcomes family, friends and significant others to be part of the healing journey.

More information on **Living Recovery** 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 call ***1800 742 466***.

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# Living Recovery Referral Form

## 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 Disorders and/or Mental Health Distress
- Details of Forensic History (if any)
- Current Medication Plan
- NDIS Plan (if applicable)
- Current Community Treatment Order (CTO)
- Brief Risk Assessment (completed by a clinician)
- Physical Health Assessment
- Mental Health Treatment/Care Plan or Care Summary
- Recent Discharge Summaries (last 12 months)
- PSOLIS Alerts

A referral will be deemed incomplete until we have received all of this information and will be returned to the referrer.

Do not hesitate to contact our intake team if you have any questions and a member of the team will be happy to help. Call us on ***9350 8800*** or email ***intake@rw.org.au***

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# Living Recovery Referral Form

## 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 | | | |

## Preferred method of contact

Text
Phone call
Email
Mail

## What was your sex recorded at birth?

***Note - there is a separate question about gender**

Female
Male
Another term (please specify):

## How do you describe your gender?

**Gender refers to current gender, which may be different to sex recorded at birth and may be different to what is indicated on legal documents.**

Man or male
Woman or female
Non-binary
Prefer not to say
[I/They] use a different term (please specify):

## Were you born with a variation of sex characteristics (sometimes called 'intersex' or 'DSD')?

Yes
No
Unsure/ Dont know
Prefer not to say

## How do you describe your sexual orientation?

Straight (heterosexual)
Gay or lesbian
Bisexual
I use a different term (please specify):
Unsure/Dont know
Prefer not to answer

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# Living Recovery Referral Form

## Applicant to Complete (cont.)

### Pronouns

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

### Relationship status

Single
Divorced
Self Describe:
Married
Widowed
Separated
Defacto

### Do you identify as Aboriginal or Torres Strait Islander?

Yes - Aboriginal
No
Yes - Torres Strait Islander
Prefer not to Say
Yes - Aboriginal and Torres Strait Islander

### Ethnicity

### Visa status

### Country of Birth

### Do you identify as Culturally and Linguistically Diverse (CaLD)?

Yes
No
Prefer not to say

### Main language spoken

English
Other:

### Interpreter required

Yes
No

### Children

Yes
No

### Source of income

Age pension
Youth allowance
Carer allowance
Paid work
Disability pension
Department of Veteran's Affairs
Unemployment (Newstart)
Other:

| Centrelink Number | | Expiry | |
|---|---|---|---|

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# Living Recovery Referral Form

## Applicant to Complete (cont.)

### Living

Living independently
Living with family member/carer

Other:

### Medicare details

| Medicare Number | | Expiry | |
|---|---|---|---|

### Private health cover

Yes
No

| Provider | | Member ID | |
|---|---|---|---|

### Ambulance cover

Yes
No

### Are you currently receiving services from another program within Richmond Wellbeing?

Yes
No

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# Living Recovery Referral Form

## Contacts

### Nominated support person (next of kin / alternative contact)

| Name | | Relationship | |
|---|---|---|---|
| Phone | | Mobile | |
| Email | | | |

### Do you have a case manager? Yes No

| Name | | Organisation | |
|---|---|---|---|
| Phone | | Mobile | |
| Email | | | |

### Do you have a guardian appointed? Yes No

| Name | | Email | |
|---|---|---|---|
| Phone | | Mobile | |

### Do you have a public trustee appointed? Yes No

| Name | | Email | |
|---|---|---|---|
| Phone | | Mobile | |

### Do you have a GP? Yes No

| Name | | Email | |
|---|---|---|---|
| Phone | | Mobile | |

### Which of the above is your preferred contact?

Support person
Case manager
Guardian appointment
Public trustee
GP

### What is their preferred contact method?

Text
Phone Call
Email
Mail

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# Living Recovery Referral Form

## Health and Wellbeing

**Existing NDIS Plan?** Yes No NDIS Plan Number:

**Formal mental health diagnosis?** Yes No

If yes, please provide details.

## Alcohol and other drugs use

Provide details where appropriate.

| Drug Type | History of Use | Current Use |
|---|---|---|
| Alcohol | | |
| T.H.C. (Cannabis) | | |
| Benzodiazepines | | |
| Opioids | | |
| Stimulants<br>Amphetamines<br>Dexamphetamines A | | |
| Other<br>Hallucinogens<br>MDMA - Ecstasy<br>Prescription Drugs<br>Solvents<br>Any other? | | |
| Cigarettes | | |

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# Living Recovery Referral Form

## Health and Wellbeing (cont.)

### Any associated risk behaviours or problems?

(e.g. self injury, risk of overdose, blood borne disease)

### 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

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# Living Recovery Referral Form

## Mental and Physical Health

Tick all that apply and provide details below.

| Title | Yes | No |
|---|---|---|
| Diabetes | ☐ | ☐ |
| Bruise or bleed easily | ☐ | ☐ |
| Heart complaints | ☐ | ☐ |
| Liver disease | ☐ | ☐ |
| Epilepsy | ☐ | ☐ |
| HIV/AIDS | ☐ | ☐ |
| High or low blood pressure | ☐ | ☐ |
| Speech | ☐ | ☐ |
| Visual | ☐ | ☐ |
| Hearing | ☐ | ☐ |
| Mobility impairments | ☐ | ☐ |
| Respiratory disease | ☐ | ☐ |
| Intersex variation | ☐ | ☐ |
| Other (please state) | ☐ | ☐ |

| Title | Yes | No |
|---|---|---|
| Podiatry | ☐ | ☐ |
| Dental | ☐ | ☐ |
| Ulcerations | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Allergies | ☐ | ☐ |
| Allergic to medication | ☐ | ☐ |
| Acquired head injury | ☐ | ☐ |
| Thyroid problems | ☐ | ☐ |
| Eating disorders | ☐ | ☐ |
| Substance abuse | ☐ | ☐ |
| Women's health screens | ☐ | ☐ |
| Men's health screens | ☐ | ☐ |
| Transgender health screens | ☐ | ☐ |
| | | |

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:

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# Living Recovery Referral Form

## Mental and Physical Health (cont.)

### Medication

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

**Do you take regular medication?** Yes No

(Please attach your medication regime)

**Do you require support taking your medications?** Yes No

**Do you use a Webster Pack?** Yes No

**Any hospital admissions in the last 12 months?** Yes No

Provide full details of any admissions (including date and reason)

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# Living Recovery Referral Form

## History and Support

### Forensic History

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

If yes, please provide details.

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### Support Needs

**How many days a week do you require support?**

**Are there any particular takes you find challenging?**

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# Living Recovery Referral Form

## History and Support (cont.)

### What support do you require?

(Tick all that apply)

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

Please provide details:

### Additional comments

### Emergency/Early Exit Plan

**Have you made any arrangements in the event of an emergency/early exit?** Yes No

*In the event you are required to leave the program early, where will you go? Please provide details:

# Living Recovery Referral Form

## History and Support (cont.)

### Emergency/Early Exit Plan

**Have you made any arrangements in the event of an emergency/early exit?** Yes No

*In the event you are required to leave the program early, where will you go? Please provide details:

**Do you have confirmed accommodation after exiting Living Recovery?**

Please provide details:

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# Living Recovery Referral Form

## Consent

### Terms and Conditions

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 Administration Tribunal.*

| **Guardian signature** | | **Date** | |
|---|---|---|---|

*If you have a guardian, please email your completed form to them to digitally sign and email it back to you.*

*Once you received the signed copy back, please email the form to your healthcare professional to finalise and submit.*