Referral Form:
Mental Health Step Up Step Down Service- Bunbury

Richmond Wellbeing's **Mental Health Step Up Step Down Service - Bunbury** (SUSD) is equipped with 10 furnished units and is a short-stay residential support service located in Glen Iris, Bunbury – with the maximum length of stay being 28 days. SUSD is an adult service, however applications for people aged 16-17 years of age will be accepted on an individual basis. (Guardian consent and additional assessment may be undertaken to ensure suitability and safety of participants within this age range.)

Step up services provide additional recovery support for individuals in the community, who are experiencing mental distress who do not require acute inpatient care.

Step down services provide support where individuals no longer require acute inpatient care yet require additional supports to assist with their personal wellbeing, recovery journey and the transition back into the community. The Richmond Wellbeing SUSD is not a substitute for inpatient hospitalisation, as it does not provide emergency or crisis accommodation services.

Referrals can be made by:

- A Psychiatrist
- A Clinical Mental Health Service
- A General Practitioner
- An Acute Hospital Unit (this includes emergency departments)

Once a SUSD referral is received, it will be assessed for eligibility & suitability. A panel will review the information to determine the needs of the person and what the service offers. The applicant and referring parties will be advised of the referral outcome within 48 hours.

Please refer to the following checklist to ensure your referral is complete and all relevant information is available on BOSSNET.

Step Up Step Down supporting documents:

Brief Risk Assessment (completed by GP or treating doctor)

Client Management Plan (from hospital) or Mental Health Care Plan (from GP)

Physical Health Assessment (completed by GP or treating doctor)

Recent Discharge Summaries

Details of Forensic History (if relevant)

Any current Community Treatment Order (CTO)

Wellness Plan

Medication regime

NDIS plan (if applicable)

Referral Form:
Mental Health Step Up Step Down Service- Bunbury

Admission Eligibility

Individuals aged 18 and over, and:

- Have a mental health condition and are currently linked in with a Psychiatrist, General Practitioner, or Clinician
- No longer require ACUTE care in an inpatient setting
- Are willing to commit to participate in a SUSD recovery program and to live within the Community Living Agreement
- Have a confirmed residence within the South West Geographical Catchment area and confirmed exit plan
- Have a current Mental Health Care Plan, Risk Assessment and Medication Profile
- Are willing to undergo a Physical Health Assessment upon entry (if one is not available prior to time of entry).

Service requests for individuals of 16-17 years of age, or older than 64 years of age, will be accepted on an individual basis. Guardian consent and additional assessment may be undertaken to assure suitability and safety of participants within these age ranges.

For further information please visit our website **www.rw.org.au**, call **1800 742 466**
or email our Intake Officer at **susd.intake@rw.org.au**

Step Up Step Down 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

Step Up Step Down Referral Form

Applicant to Complete (cont.)

Pronouns

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

Relationship status

Single	Divorce	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	

Step Up Step Down 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

Step Up Step Down 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

Step Up Step Down 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 Drug use

Provide details where appropriate.

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

Step Up Step Down Referral Form

Health and Wellbeing (cont.)

Would you like access to an alcohol & drug counsellor for support during your stay? Yes No

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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Step Up Step Down 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	☐	☐
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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Step Up Step Down 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 profile from your treating Doctor)

Will you self-manage your medications (with support) while at SUSD? Yes No

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Do you use a Webster Pack? Yes No

Any hospital admissions in the last 12 months?

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

Step Up Step Down Referral Form

History and Support

Any attempts at suicide in the last 6 months? Yes No

Forensic History

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

If yes, please provide details.

Are there any current orders, such as Violence Restraining Orders, Child Protection Orders, Supervision Orders, etc? Yes No

If yes, please provide details.

Step Up Step Down Referral Form

History and Support (cont.)

What support do you require?

(Tick all that apply)

Support	Tick	Support	Tick
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

Step Up Step Down 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, including address:

Do you have confirmed accommodation within the South West geographical catchment area?

Yes No

Please provide details, including address.

Upon completion of the service do you have confirmed accommodation? Yes No

Please provide details, including contact name, phone number and address:

Step Up Step Down 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	
Guardian signature*		Date	

* Required if under Guardianship. Please also provide a copy of your Guardian Order issued by the State Administrative Tribunal.

To submit please email completed form, along with required documents, to our Intake Officer at **susd.intake@rw.org.au**

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BRIEF RISK ASSESSMENT

RESIDENTIAL REFERRAL

PATIENT DETAILS

Surname:		First Names(s):	
Patients Address:		Post Code:	
UMRN:	Gender:	Birth Date:	

SOURCES OF INFORMATION

Previous Clinical Records

Assessing clinician's knowledge of consumer's past behaviour/ current clinical presentation

Medical

Police/Ambulance/Other agencies

Other: (Please Specify)

SUICIDALITY

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

Protective Factors *(describe)*

Level of Suicide Risk *(total score)*	LOW (<7)	MODERATE (7-14)	HIGH (>14)

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BRIEF RISK ASSESSMENT

RESIDENTIAL REFERRAL

AGGRESSION/VIOLENCE

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

Protective Factors *(describe)*

Level of Aggression/Violence *(total score)*	LOW (<7)	MODERATE (7-14)	HIGH (>14)

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BRIEF RISK ASSESSMENT

RESIDENTIAL REFERRAL

Other Risks Identified (and Risk Factors)

Risk Management Issues (please ensure Psolis alerts are noted here)

TO BE COMPLETED BY ASSESSING CLINICIAN

Full Name:			
Signature:		Date:	
Organisation/Facility:		Position Held:	
Address:		Phone:	

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Physical Health Assessment

PATIENT DETAILS

Surname:

First Names(s):

Patients Address:

Post Code:

UMRN:

Gender:

Birth Date:

SOURCES OF INFORMATION

Previous Clinical Records

Assessing clinician's knowledge of consumer's past behaviour/ current clinical presentation

Medical

Police/Ambulance/Other agencies

Other: (Please Specify)

PRACTITIONER GP DETAILS

Address:

Contact Number:

Provider Number:

CONSUMER DETAILS

Height

Weight

Pulse

Blood Pressure

Temperature

Do yo have any of the following conditions?	Yes/No	If yes, please provide details
Diabetes		
Heart disease		
Breathing difficulties		
Urinary problems		
Bowel problems		

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Mobility difficulties		
Hearing issues		
Visual difficulties		
Allergies		
High Cholesterol		
Recent Operations		
Family history of medical issues		
Pain Management		
Communication issues		
Other relevant medical history		

TO BE COMPLETED BY ASSESSING CLINICIAN

Full Name:			
Signature:		Date:	
Organisation/Facility:		Position Held:	
Address:		Phone:	