Referral Form:
Living Well - Mental Health Community Care Unit

About the service

Based in Orelia, **Living Well – Mental Health Community Care Unit** offers intensive, transitional support for people with complex mental health issues. The service is staffed twenty-four hours per day, seven days per week.

The service offers five share houses (twenty beds) set in a homelike environment that supports recovery in all its forms.

With a person-centred and recovery-based approach, Living Well supports residents to:

- develop and reach individual goals
- work towards independent living skills
- make informed choices
- develop social skills
- reconnect with family, community, clinical and non-clinical supports.

A tailored approach to everyone's individual needs and the provision of a safe environment in which to grow makes Living Well a great way to reconnect with the community. Residents will work closely with a multi-disciplinary team to plan and action the life of their choosing.

Our practice is trauma-informed, ensuring physical, psychological, and emotional safety for all residents accessing support through the Living Well service.

About the team

The team at Living Well has been created in close partnership with Cyrenian House and Rockingham and Peel Community Mental Health, to ensure that we provide the best support possible for a holistic and individualised experience.

The Recovery Program will include one on one support and skill development as well as group work, all programmed activities are intentional and meaningful and complimented with social activities, where possible immersed in the community.

Residents will have access to Recovery Workers, Clinical staff , Recovery Support Workers, Alcohol and Other Drug Counsellors and a Transition Support Coordinator.

Eligibility & service entry criteria

- ☐ Aged between 18* and 65 years
- ☐ Have complex mental health issues
- ☐ Requires intensive recovery support to live well
- ☐ Require a Brief Risk Assessment and Medication Profile
- ☐ Does not require acute inpatient admission and treatment

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

For further information, please visit our website ***www.rw.org.au***, call us on ***9350 8800*** or email ***intake@rw.org.au***

Living Well CCU Referral Form

Supporting Documents Checklist

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
- [ ] Proof of Income

A referral will be deemed incomplete until we have received all relevant supporting documentation.

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***

Living Well CCU 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

Living Well CCU Referral Form

Applicant to Complete (cont.)

Pronouns

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

Relationship status

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Defacto
- ☐ Self Describe:

Do you identify as Aboriginal or Torres Strait Islander?

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

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

Centrelink Number		Expiry	

Living Well CCU 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

Living Well CCU 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

Living Well CCU 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 ☐ Amphetamines ☐ Dexamphetamines A		
Other ☐ Hallucinogens ☐ MDMA - Ecstasy ☐ Prescription Drugs ☐ Solvents ☐ Any other?		
Cigarettes		

Living Well CCU Referral Form

Health and Wellbeing (cont.)

Would you like access to an alcohol and 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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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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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)

Will you self-manage your medications (with support) while at Living Well CCU? ☐ 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)

Date	Hospital	Reason for Admission

Living Well CCU Referral Form

History and Support

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.

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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

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 Well CCU 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 ***intake@rw.org.au***

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
- ☐ Medical
- ☐ Other: (Please Specify)
- ☐ Assessing clinician's knowledge of consumer's past behaviour/ current clinical presentation
- ☐ Police/Ambulance/Other agencies

SUICIDALITY

Static (historical) risk factors	Yes (1)	No (0)	Not Known	Dynamic (current) risk factors	Yes (2)	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)

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)

BRIEF RISK ASSESSMENT

RESIDENTIAL REFERRAL

Other Risks Identified

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:	

Physical Health Assessment

PATIENT DETAILS

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

SOURCES OF INFORMATION

- ☐ Previous Clinical Records
- ☐ Medical
- ☐ Other: (Please Specify)
- ☐ Assessing clinician's knowledge of consumer's past behaviour/ current clinical presentation
- ☐ Police/Ambulance/Other agencies

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		

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: