Richmond Wellbeing

Referral Form:

Momentum QP - Youth Mental Health, Alcohol and other Drugs Homelessness Service

About the service

Momentum QP - Youth Mental Health and Alcohol and Other Drug (AOD) Homelessness Service in Queens Park supports young people with mental health issues, with or without co-occurring AOD issues, to transition from homelessness and move to independent living by supporting them on their recovery journey. **Momentum QP** has capacity to work with 8 young people at any time in the residential program for a period of up to 12 months where they will receive support from the multidisciplinary team to work intensively on their recovery towards building a meaningful life beyond distress. Recovery programs are provided in a residential setting and delivered using a culturally informed and person-centred approach.

The work is embedded in person driven practice principles, providing psychosocial support to enable personal recovery.

Momentum QP is delivered by Richmond Wellbeing in partnership with Anglicare WA, Cyrenian House and Royal Perth Bentley Group. The service is funded by the Mental Health Commission.

Eligibility & service entry criteria

Momentum QP assists young people aged 16 to 24 years who meet all of the below criteria:

Are experiencing mental health distress with or without co-occurring AID issues.
Are homeless or at risk of being homeless
In respect to young people who have co-occurring AOD challenges, will have undertaken a detoxification prior to accessing the service, if necessary.
Willingness of the young person to participate in the structured program
Confirmed involvement of a Public or Private Clinical Case Management or GP

Momentum QP will

- provide care and support for young people with mental health (with or without co-occurring AOD) issues within a residential setting
- offer cultural security
- be trauma-informed
- promote personal recovery
- focus on whole of life and quality of life needs
- provide services that will be delivered by a combination of psychosocial and clinical activities and interventions
- support transition to suitable, stable and safe accommodation

Applications are reviewed by an intake panel consisting of our multidisciplinary staff team with consumer representatives. The service is staffed 24 hours a day, 7 days a week. **Momentum QP** is available to eligible young people throughout WA.

More information on this 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 by calling ***9350 8800.***

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Momentum QP 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

Momentum QP 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	

Momentum QP Referral Form

Applicant to Complete (cont.)

Does someone else manage your money?

Yes No

If yes, who (e.g. Public Trustee)		Name	
Address		Contact Number	

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

Momentum QP 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 or advocate appointed? Yes No

Name		Email	
Phone		Mobile	

Do you have a GP? Yes No

Name		Email	
Phone		Mobile	

Do you have a Chemist/Pharmacy? Yes No

Name		Email	
Phone		Mobile	

Do you have a Psychologist? Yes No

Name		Email	
Phone		Mobile	

Momentum QP Referral Form

Contacts

Which of these contacts is your preferred contact?

- Support person
- Case manager
- Guardian
- Public trustee
- GP
- Chemist/Pharmacy
- Psychologist

What is their preferred contact method?

- Text
- Phone Call
- Email
- Mail

Momentum QP 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		

Momentum QP 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

Momentum QP Referral Form

Mental and Physical Health (cont.)

Medication

Do you take regular medication? Yes No

(Please attach your medication regime)

Will you self-manage your medications (with support) while at Momentum QP? 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

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Momentum QP 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)

Support		Support	
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

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Living Well CCU 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:

Has this exit plan been confirmed with the person listed above? Yes No

If you are unsuccessful in gaining admission to Momentum QP, would you like to be considered for other Richmond Wellbeing services? Yes No

Is there anything else you would like to add?

:

Momentum QP Referral Form

Checklist

Required Documents:

- Proof of age (e.g. school enrollment, letter from Centrelink or GP with DOB details) or case manager
- Proof of income to demonstrate the applicant's ability to pay the service's rent (e.g. Centrelink)
- Current Client Management Plan confirming the applicant in experiencing mental health distress
- Brief Risk Assessment completed by clinician
- Physical Health Assessment completed by a clinician
- A copy of the applicant's current physical and mental health treatment/Care plan
- Legal reporting requirements

Further Supporting Documents (if applicable):

- Recent Discharge Summaries (if any)
- Medication regime (if any)
- Signed and dates consent from the applicant to the referrer to apply on their behalf
- Signed and dated guardianship order
- Any current Community Treatment Order [CTO]
- Advance Consent Directive [AHD]
- Details of Forensic History (if any)
- NDIS Plan

Momentum QP Referral Form

Consent (cont.)

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 Momentum QP** service:

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***

If you require further assistance please call out Intake Team on ***9350 8800.***

Consent

Consent to release information

I [Full name] [Date of Birth] authorise **Richmond Wellbeing** to release information to 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 Momentum QP.

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			
Parents/Advocate/ Guardian/Carer where appropriate			
Others			
Signature		Date	

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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 (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)

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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

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:	