Referral Form:
PaRK Service (Peel, Rockingham and Kwinana)

About the service

PaRK is a community-based supported accommodation service for individuals with severe and persistent mental distress requiring individual customised care. Our culturally appropriate and dedicated service will work with you to develop valuable life skills to increase confidence, independence and engagement in the community. We support you to participate in your recovery journey and can assist with employment, social, recreational and education activities. We can also assist in accessing NDIS services.

The shared accommodation in our five houses within the Mandurah, Rockingham and Baldivis area are provided for up to twelve months. Support is provided Monday – Friday, 8 am to 5 pm.

At the end of 12 months we can continue to provide outreach support for a further six months to help with the transition from supported accommodation into the community.

Eligibility & service entry criteria

To be eligible for Richmond Wellbeing accommodation services, the applicant must be between 18 to 65 years of age.

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

PaRK Service 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

If a referral is incomplete or has conflicting information, it will be returned to the referrer for updating and completion.

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***

PaRK Service 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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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

PaRK Service Referral Form

Applicant to Complete (cont.)

Do you hold a DVA card? ☐ Yes ◯ No

If yes, what type? ☐ Gold ◯ White ◯ Other

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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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

PaRK Service 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		

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Health and Wellbeing (cont.)

Any associated risk behaviours or problems?

(e.g. injecting, overdoses, Hepatitis status)

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

PaRK Service 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:

PaRK Service 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 medication? ☐ 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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History and Support

Any attempts at suicide in the last 6 months?

If yes, please provide details.

☐ Yes ◯ No

Forensic History

Do you have any past or current legal issues?

If yes, please provide details.

Support Needs

How many days a week do you require support?

Are there any particular tasks you find challenging?

PaRK Service 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:

PaRK Service 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.

☐ I consent to be referred to alternate Richmond Wellbeing services in the event that my first choice is unavailable.

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, please email the form to your healthcare professional to finalise and submit.

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: