



Referral Form:

Residential Accommodation Services

BASSENDEAN

This is a community based, home-like environment that offers long-term accommodation. Bassendean is a recovery focused program for people with severe and persistent mental ill health requiring a high level of support. The expectation is that residents will progress to more independent living arrangements. Support staff are available on site at all times.

Accommodation consists of three separate villas on one campus. Each villa contains four bedrooms. The villas may consist of both male and female residents. Support staff are available on site 24 hrs. 7 days a week.

BUNBURY & BUSSELTON

The CSRU (Community Supported Residential Units) offers a medium to long-term personalised psychosocial support linked to housing. The length of stay is not limited, however, residents are supported on their journey towards mental health recovery and independent living. Support staff are available on site 24 hrs. 7 days a week.

KELMSCOTT

Community Options in Kelmscott provides a long term, recovery based residential service following long term hospitalisation. The service provides person centred support 24 hours a day, seven days a week for people with a severe and persistent mental illness. We work closely with the local public mental health services to provide ongoing clinical support.

Each resident will have a dedicated key worker to work with them on their personal recovery plan, as well as access to recovery based groups and activities which will provide opportunities to develop living skills, participate in community and social activities and access support and information.

QUEENS PARK

Richmond Wellbeing Queens Park service offers long term recovery based support for individuals aged 18-65. The service offers 24 hour support and assistance to work alongside individuals in all aspects of their health and well-being and activities of daily living. The ten bed service offers highly individualised and group support to develop the life of your choosing.

NGULLA MIA

Noongar for Our Place, Ngulla Mia is located in central Perth. This service is for people experiencing mental health issues who are homeless or at risk of being homeless. This service has capacity to support 32 adults. People can stay for up to 12 months to work with the support of a Keyworker, to work intensely on their recovery toward building a meaningful life beyond crisis and distress. We work in a person centred approach to enable recovery through psychosocial supports. The team work according to recovery enabling, person driven practice principles, providing psychosocial support to enable personal recovery.

Applications are reviewed by a panel consisting of our staff, a consumer representative and staff from the relevant mental health services. People using this service are required to have the support of a mental health case worker. The service is staffed 24 hours per day, seven days a week.

Referral form:

Residential Accommodation Services

To be eligible for Richmond Wellbeing accommodation services, if experiencing substance use issues the applicant must agree to work with an appropriate drug and alcohol service (if relevant) and not bring any alcohol and other drugs into the residential service and be between 18 and 65 years of age.

More information on each of these services 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 1800 742 466.

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**

Residential 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

Residential 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

Interpreter required

English

Other:

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

Residential 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/carers

Other:

What service would you like to be referred to?

Bunbury

Busselton

Bassendean

Ngulla Mia

Kelmscott

Queens Park

Preferred Service

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

Residential 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

Public trustee

Case manager

GP

Guardian appointment

What is their preferred contact method?

Text

Email

Phone Call

Mail

Residential Referral Form

Health and Wellbeing

Please attach a Physical Health Assessment form

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		

Residential 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

Residential Referral Form

Mental and Physical Health

Tick all that apply and provide details below.

Title	Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Bruise or bleed easily	<input type="checkbox"/>	<input type="checkbox"/>
Heart complaints	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Speech	<input type="checkbox"/>	<input type="checkbox"/>
Visual	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>
Mobility impairments	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>
Intersex variation	<input type="checkbox"/>	<input type="checkbox"/>
Other (please state)	<input type="checkbox"/>	<input type="checkbox"/>

Title	Yes	No
Podiatry	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerations	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Allergic to medication	<input type="checkbox"/>	<input type="checkbox"/>
Acquired head injury	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorders	<input type="checkbox"/>	<input type="checkbox"/>
Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>
Women's health screens	<input type="checkbox"/>	<input type="checkbox"/>
Men's health screens	<input type="checkbox"/>	<input type="checkbox"/>
Transgender health screens	<input type="checkbox"/>	<input type="checkbox"/>

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:

Residential 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 from your treating Doctor)

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)

Residential Referral Form

History and Support

Any attempts at suicide in the last 6 months?

Yes

No

If yes, please provide details.

Forensic History

Do you have any past or current legal issues?

Yes

No

If yes, please provide details.

Support Needs

How many days a week do you require support?

Are there any particular tasks you find challenging?

Residential Referral Form

History and Support (cont.)

What support do you require?

(Tick all that apply)

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

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:

Residential 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

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 <i>(describe)</i>							
Level of Suicide Risk <i>(total score)</i>				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 <i>(describe)</i>							
Level of Aggression/Violence <i>(total score)</i>				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:

Organisation/Facility:

Address:

Date:

Position Held:

Phone:

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 you 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:

Organisation/Facility:

Address:

Date:

Position Held:

Phone: