

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, or older than 64 years of age may 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 wish to avoid the need for an inpatient admission.

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

Admission Eligibility

To be eligible for the service, individuals must:

- Have a diagnosed mental health condition and receive support from a Psychiatrist, General Practitioner, or Mental Health Clinician,
- No longer require acute care in an inpatient setting,
- Be committed to participating in a SUSD recovery program, and to living within the Community Living Agreement,
- Have a confirmed residence within the South West Geographical Catchment area and confirmed exit address,
- Have a current Risk Assessment and Medication Profile / list, and,
- If required, be willing to undergo a Physical Health Assessment upon entry.

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

To view the site, please follow these steps to view the online virtual tour:

- Using your preferred browser, search Richmond Wellbeing - select organisation website
- Select the 'Supported Accommodation' tab from the options bar
- Scroll down to 'Mental Health Step Up Step Down Bunbury' - select.

To arrange an in-person viewing of the site, contact the SUSD office on 9726 0748.

Step Up Step Down Referral Form

Referrer details

Name		Agency/Position	
Postal Address			Postcode
Phone		Email	

Applicant to complete

First Name		Family Name	
Preferred Name		Date of Birth	
Address			Postcode
Phone		Mobile	
Email			

Preferred method of contact:

Diversity Considerations

Aboriginal / Torres Strait Islander (ATSI) If yes, where is your country?

Culturally & Linguistically Diverse (CALD) Main language spoken:

Sex recorded at birth (optional)

Gender Identity Diversity Orientation

Pronouns Other:

Diagnoses

Primary mental health diagnosis:

Secondary diagnosis (if applicable):

Living Arrangements

Living independently Sharing housing

Carer / family Other

Other living arrangements (specify):

Step Up Step Down Referral Form

Health Details

Medicare

Ambulance cover

Private health

Source of income

Employed

Centrelink

Other (please specify):

Contacts

Nominated support person (next of kin / alternative contact)

Name		Relationship	
Phone		Mobile	
Email	I am the referrer (contact details enter on page 2)		

Do you have a care coordinator?

Yes

No

Name		Relationship	
Phone		Mobile	
Email	I am the referrer (contact details enter on page 2)		

Do you have a general practitioner?

Yes

No

Please be aware that, while a Senior Medical Officer can be accessed on site, all physical health concerns will need to be discussed with your GP.

Name		Organisation	
Phone		Mobile	
Email	I am the referrer (contact details enter on page 2)		

Do you have a guardian appointed?

Yes

No

Name		Email	
Phone		Mobile	
Email	I am the referrer (contact details enter on page 2)		

Do you have a psychologist, counsellor or psychotherapist?

Yes

No

Name		Email	
Phone		Mobile	
Email	I am the referrer (contact details enter on page 2)		

Step Up Step Down Referral Form

Contacts Continued

Do you have any additional services involved in your care?

E.g.: Public trustee, Guardian, NDIS, support groups or programs
If yes, please provide details:

Yes

No

Health and Wellbeing

Medication profile attached? (Required)

Yes

No

Medication Support

Yes

No

Allergies:

Nil

Assistance required with personal care?

Yes

No

Significant medical history / diagnosis

Yes

No

If yes, please provide details:

Step Up Step Down Referral Form

Alcohol and other substance use

Do you have a history of dependence on alcohol or other substances

(including prescription medication). If yes, please provide details: Yes No

Do you smoke?: (Including vaping/e-cigarette or other nicotine products) Yes No

Substance type:

Amount typically used:

Frequency of use:

Date of last use:

Current Supports:

Step Up Step Down Referral Form

History and Support

Forensic / legal history Yes No

Current forensic / legal considerations? (Current orders such as VRO, CTO, etc) Yes No

Alerts / Safety issues: Yes No

(History of violence or aggression, suicidal & self-harm risk, vulnerable to exploration)

If the answer to any of the above is yes, details must be provided in the box below for the referral to be progressed.

Current presenting problems:

Step Up Step Down Referral Form

Outcome

What is the preferred method for notification regarding the outcome of this referral:

Notify applicant directly - as per preferred method of contact (selected pag 2)

Notify referrer directly (case manager, psych, GP, APU, etc.)

Contact next of kin

Contact support services (support workers, etc.)

Reason for referral - Applicant to complete

Please reflect on and provide a brief response to the following:

1. What goals would you like to work on if you came to SUSD?
2. How could the team at SUSD support you in your recovery / wellbeing?
3. What supports will you need to put in place to enable you to return home?
4. What does a good day look like to you?
5. What do your days currently look like

Note: If you are completing this referral on behalf of the applicant, this section is to be completed by the applicant independently. If they are unable to do so without assistance, please leave blank.

Step Up Step Down Referral Form

Exit Plan

Emergency / Exit Plan

In the event of a significant incident, increase in risk / acuity, impact on community harmony, the resident may be exited from SUSD.

Exit address:

(to be within the South West Geographical Catchment)

If the above address is not your own, please provide contact details for SUSD to confirm your elected exit address.

Consent

Terms and conditions

I acknowledge the information provided is true and correct. I understand that I may be exited from the service for the reasons stated above. I consent to Richmond Wellbeing contacting my next of kin, health service providers or other contacts indicated on this form in order to assist with my referral.

Applicant:

Full Name:			
Signature:		Date:	

Referrer:

Full Name:			
Signature:		Date:	

Step Up Step Down Referral Form

Referral Submission

SUSD is unable to proceed with the referral unless the following are included in the application.

Note: All additional documents must be current information.

[1] Ramp and/or BRA

[2] Medication Profile

Providing additional documents such as Mental Health Care Plan, Client Management Plan, previous Hospital Discharge Summary, is encouraged.

Once a SUSD referral is received, it will be assessed for eligibility & suitability.

A panel will review the information provided and an outcome will be provided within 72 hours to the above preferred contact.

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

Please contact SUSD on **9726 0748** if you have any questions.

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: