Residential Accommodation Services Referral Form

What service would you like to be referred to? Select one option

- ☐ Bunbury CSRU
- ☐ Busselton CSRU
- ☐ Bassendean Individualised Support
- ☐ Ngulla Mia
- ☐ Kelmscott Community Options
- ☐ Queens Park
- ☐ Momentum QP
- ☐ Living Well CCU
- ☐ PaRK Service

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

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

Referrer details

Name		Agency/Position	
Postal Address		Postcode	
Phone		Email	

How did you hear about us?

- ☐ Website
- ☐ Social Media
- ☐ Event
- ☐ Friend / family / a client
- ☐ Radio
- ☐ Google
- ☐ Flyer
- ☐ Advertising
- ☐ Other

Applicant to complete

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

Preferred method of contact

- ☐ Text
- ☐ Email
- ☐ Phone call
- ☐ Mail

What was your sex recorded at birth? *Note - there is a separate question about gender

- ☐ Female
- ☐ Male
- ☐ Another term (please specify):

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.

- ☐ Female
- ☐ Transgender Female (MTF)
- ☐ Male
- ☐ Transgender Male (FTM)
- ☐ Prefer not to disclose
- ☐ Non-Binary
- ☐ Self-describe:
- ☐ Different identity:

Were you born with a variation of sex characteristics (sometimes called 'intersex' or 'DSD')?

- ☐ Yes
- ☐ Unsure/ Don't know
- ☐ No
- ☐ Prefer not to say

How do you describe your sexual orientation?

- ☐ Straight (heterosexual)
- ☐ Bisexual
- ☐ Unsure/Dont know
- ☐ Gay or lesbian
- ☐ I use a different term:
- ☐ Prefer not to answer

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
- ☐ JobSeeker payment
- ☐ Youth allowance
- ☐ Paid work
- ☐ Department of Veterans' Affairs
- ☐ Other:

Centrelink Number		Expiry	

Living

☐ Living independently ☐ Living with family member/carer

☐ Other:

Do you hold a DVA card?

☐ Yes ☐ No

If yes, what type?

☐ Gold ☐ White ☐ 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 Richmind WA?

☐ Yes ☐ No

Contacts

Nominated support person (next of kin/alternative contact)

Name		**Relationship**	
Phone		**Mobile**	
Email			

Do you have a case manager?

☐ Yes, please provide details ☐ No

Name		**Organisation**	
Phone		**Mobile**	
Email			

Do you have a guardian appointed?

☐ Yes, please provide details ☐ No

Name		**Phone**	
Email		**Mobile**	

Do you have a public trustee appointed?

☐ Yes, please provide details ☐ No

Name		**Phone**	
Email		**Mobile**	

Do you have a GP?

☐ Yes, please provide details ☐ No

Name		**Phone**	
Email		**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

Health and Wellbeing

Existing NDIS Plan?

☐ Yes, NDIS Plan Number: ☐ No

Formal mental health diagnosis?

☐ Yes, please provide details ☐ No

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		
Other ☐ Hallucinogens ☐ MDMA - Ecstasy ☐ Prescription Drugs ☐ Solvents ☐ Any other		
Cigarettes		

Any associated risk behaviours or problems?

e.g. self injury, risk of overdose, blood borne disease ☐ Yes, please provide details ☐ No

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

Mental and Physical Health Tick all that apply and provide details below.

Title	Yes	Title	Yes
Diabetes	☐	Podiatry	☐
Bruise or bleed easily	☐	Dental	☐
Heart complaints	☐	Ulcerations	☐
Liver disease	☐	Asthma	☐
Epilepsy	☐	Allergies	☐
HIV/AIDS	☐	Allergic to medication	☐
High or low blood pressure	☐	Acquired head injury	☐
Speech	☐	Thyroid problems	☐
Visual	☐	Eating disorders	☐
Hearing	☐	Substance abuse	☐
Mobility impairments	☐	Women's health screens	☐
Respiratory disease	☐	Men's health screens	☐
Intersex variation	☐	Transgender health screens	☐
Other (please state)	☐		

If yes, please provide details. Include the impact on your life and relating support needs.

Do you have any mobility aids?

If yes, please provide details

Medication

How do you feel about taking medication?

Do you take regular medication? ☐ Yes ☐ No

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

History and Support

Any attempts at suicide in the last 6 months?

☐ Yes, please provide details ☐ No

Forensic history

Do you have any past or current legal issues?

☐ Yes, please provide details ☐ No

Support needs

How many days a week do you require support?

Are there any particular tasks you find challenging?

What support do you require?

Getting in/out of bed	☐	Bathing	☐
Dressing/undressing	☐	With continence	☐
Toileting	☐	Washing	☐
Cooking	☐	Medication	☐
Eating	☐	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 for the ticked supports:

Additional comments

Emergency/Early Exit Plan

☐ Yes ☐ No

Have you made any arrangements in the event of an emergency/early exit?

*In the event you are required to leave the program early, where will you go?
Please provide details:

Consent

Terms and Conditions

I acknowledge the information provided is true and correct. I agree that Richmind WA 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 Richmind WA's Residential Accommodation Services.

☐ I consent to be referred to alternate Richmind WA services in the event that my first choice is unavailable

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 Name(s)			
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)

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	☐ LOW (<7)	☐ MODERATE (7-14)	☐ HIGH (>14)

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	
Address		Phone	

Physical Health Assessment

Patient Details

Surname		First Name(s)			
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 you have any of the following conditions?	Yes	No	If yes, please provide details
Diabetes	☐	☐	
Heart disease	☐	☐	
Breathing difficulties	☐	☐	
Urinary problems	☐	☐	
Bowel problems	☐	☐	

Do you have any of the following conditions?	Yes	No	If yes, please provide details
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	
Address		Phone	