

Residential Accommodation Services Referral Form

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

Bunbury CSRU Ngulla Mia Momentum QP

Busselton CSRU Kelmscott Community Options Living Well CCU

<u>Bassendean Individualised Support</u> <u>Queens Park</u> <u>PaRK Service</u>

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)

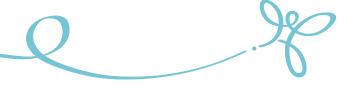
Physical Health Assessment

Mental Health Treatment/Care Plan or Care Summary

Recent Discharge Summaries (last 12 months)

PSOLIS Alerts

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





Referrer details

Name	Agency/Position
Postal Address	Postcode
Phone	Email

How did you hear about us?

Website Friend / family / a 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):

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 Prefer not to disclose

Transgender Female (MTF)

Male

Self-describe:

Transgender Male (FTM)

Different identity:

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

Yes No

Unsure/ Don't know Prefer not to say



How do you describe your sexual orientation?

Straight (heterosexual)

Gay or lesbian

Bisexual

I use a different term:

Unsure/Dont know

Prefer not to answer

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 Veterans' Affairs

JobSeeker payment

Other:

Centrelink Number

Expiry



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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 Public trustee

Case manager GP

Guardian appointment

What is their preferred contact method?

Text Email Phone Call 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.

Yes

Title	Yes	Title
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

Yes No



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? Provide full details of any admissions including date and reason	Yes	No

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

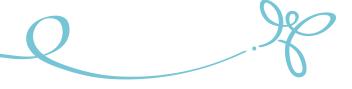
How many days a week do you require support? Are there any particular tasks you find challenging?

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	

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



^{*} Required if under Guardianship. Please also provide a copy of your Guardian Order issued by the State Administrative Tribunal.



Brief Risk Assessment

Residential referral

Patient Details									
Surname		First Name(s)							
Address			Post Code						
UMRN	Gender		Birth Date						
Sources of information									

Assessing clinician's knowledge of consumer's past **Previous Clinical Records**

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



Recent incidents of violence	(1)	(0)	Not Known	Dynamic (current) risk factors	Yes (1)	No (0)	Not Known
recent incluents of violence	()	(-7		Expressing intent to harm others	()	(-)	
Previous use of weapons				Access to available means			
Male				Paranoid ideation about others			
Jnder 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)							
_evel of Aggression/Violenc	е		LOW (<7)	MODERATE (7-14)		11GF >14)	1

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	: Detail	S							
Surname					First	Name(s)			
Address							Post Co	ode	
UMRN				Gender			Birth Da	ate	
Sources	Sources of information								
Med	beha Medical				aviour/ c	inician's ki urrent clir ulance/Ot	nical pre		r's past
Practiti	oner G	P Detai	ls						
Address									
Contact Number				Provid	er Numbe	er			
Consum	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				

