Bunbury Step Up/Step Down Referral Form

Richmond WA's Mental Health Bunbury Step Up/Step Down service (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 WA SUSD is not a substitute for inpatient hospitalisation, as it does not provide emergency or crisis accommodation services.

Referrals can be made by a/an:

- Psychiatrist
- Allied Mental Health Service Provider
- General Practitioner
- 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;
- Provide supporting documentation as per page 9 including: 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 **rw.org.au**, call **9726 0748** or email our Intake Officer at **susd.intake@rw.org.au**. Call us to arrange an in-person viewing of the site.

Referrer details

Name			
Agency/Position			
Postal Address		Postcode	
Phone		Mobile	
Email			

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)
- [ ] 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

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

Do you identify as Culturally and Linguistically Diverse (CaLD)?

- [ ] Yes
- [ ] No
- [ ] Prefer not to say

Main language spoken

- [ ] English
- [ ] Other:

Interpreter required

- [ ] Yes
- [ ] No

Living arrangements

- [ ] Living independently
- [ ] Share house
- [ ] Carer/family
- [ ] Other:

Diagnoses

Primary mental health diagnosis

Secondary diagnosis (if applicable)

Health details

☐ Medicare number:

☐ Ambulance cover number:

☐ Private health number:

Source of income

☐ Employed ☐ Centrelink ☐ Other

Please provide details:

Contacts

Nominated support person (next of kin/alternative contact)

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

☐ I am the referrer (as per contact details on p.2)

Do you have a care coordinator?

☐ Yes, please provide details ☐ No

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

☐ I am the referrer (as per contact details on p.2)

Do you receive support from Community Mental Health or a private Psychiatry team?

☐ Yes, please provide details ☐ No

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

☐ I am the referrer (as per contact details on p.2)

Do you have a GP (General Practitioner)? ☐ Yes, please provide details ☐ No

Name			
Organisation			
Phone		**Mobile**	
Email			

☐ **I am the referrer (as per contact details on p.2)**

Do you have a guardian appointed? ☐ Yes, please provide details ☐ No

Name			
Phone		**Mobile**	
Email			

☐ **I am the referrer (as per contact details on p.2)**

Do you have a psychologist, counsellor or psychotherapist?

☐ Yes, please provide details ☐ No

Name			
Phone		**Mobile**	
Email			

☐ **I am the referrer (as per contact details on p.2)**

Do you have any additional services involved in your care?

☐ Yes, please provide details ☐ No

E.g. Public Trustee, guardian, NDIS, support groups or programs

Health and Wellbeing

Medication profile attached? (Required) ☐ Yes ☐ No

Medication support ☐ Yes ☐ No

Allergies ☐ Yes, please provide details ☐ No

Assistance required with personal care? ☐ Yes, please provide details ☐ No

Significant medical history/diagnosis ☐ Yes, please provide details ☐ No

Alcohol and other substance use

Do you have a history of dependence on alcohol or other substances (including prescription medication)? ☐ Yes, please provide details below ☐ 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:

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

History and Support

Forensic / legal history	☐ Yes	☐ No
Current forensic / legal considerations? (Current orders such as VRO, CTO etc.)	☐ Yes	☐ No
Alerts / safety issues (History of violence or aggression, suicidal & self-harm risk, vulnerable to exploration)	☐ Yes	☐ No

If the answer to any of the above is yes, details must be provided below for the referral to progress:

Current presenting issues?

Outcome

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

- ☐ Notify applicant directly - as per preferred method of contact (selected page 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.

Emergency/Early 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 Richmind WA contacting my next of kin, health service providers or other contacts indicated on this form in order to assist with my referral.

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

Applicant

Full name			
Signature		**Date**	

Referrer

Full name			
Signature		**Date**	

Referral Submission

SUSD is unable to proceed with the referral unless the following are included in the application. Note: All additional documents must have current information.

1. Current Medication Profile
2. Current Community Treatment Order (CTO) if applicable
3. Brief Risk Assessment or RAMP (completed by a clinician)
4. Physical Health Assessment (when or as requested)
5. Mental Health Treatment/Care Plan or Care Summary
6. Recent Discharge Summaries (last 12 months)
7. PSOLIS Alerts (where applicable)

Once a SUSD referral is received, it will be assessed for eligibility and 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 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	