# 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<br>☐ Amphetamines<br>☐ Dexamphetamines | | |
| Other<br>☐ Hallucinogens<br>☐ MDMA - Ecstasy<br>☐ Prescription Drugs<br>☐ Solvents<br>☐ 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 | |