

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

Bassendean Individualised Support

Queens Park

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	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)	Non-Binary
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)
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

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

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	
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Private health cover

Yes

No

Provider		Member ID	
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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)

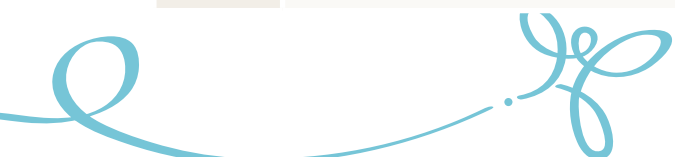
Name		Relationship	
Phone		Mobile	
Email			

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

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	<input type="checkbox"/>	Bathing	<input type="checkbox"/>
Dressing/undressing	<input type="checkbox"/>	With continence	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	Washing	<input type="checkbox"/>
Cooking	<input type="checkbox"/>	Medication	<input type="checkbox"/>
Eating	<input type="checkbox"/>	Counselling/talking to someone	<input type="checkbox"/>
Laundry	<input type="checkbox"/>	Shopping	<input type="checkbox"/>
Gardening	<input type="checkbox"/>	Cleaning	<input type="checkbox"/>
Keeping safe	<input type="checkbox"/>	Communicating	<input type="checkbox"/>
With documentation	<input type="checkbox"/>	Transport	<input type="checkbox"/>
Budgeting	<input type="checkbox"/>	Accessing medical/health appointments	<input type="checkbox"/>
Emotional support	<input type="checkbox"/>	Engaging with social groups	<input type="checkbox"/>
Advocacy (someone to talk on your behalf)	<input type="checkbox"/>	Information of services/support	<input type="checkbox"/>
Social/family contact	<input type="checkbox"/>	Psycho-education (e.g. stress management)	<input type="checkbox"/>
Computer/IT skills	<input type="checkbox"/>	Family relationships	<input type="checkbox"/>
Others (please specify)	<input type="checkbox"/>		

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	
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Guardian signature*		Date	
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** 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	No	Not	Dynamic (current) risk factors	Yes	No	Not
	(1)	(0)	Known		(2)	(0)	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

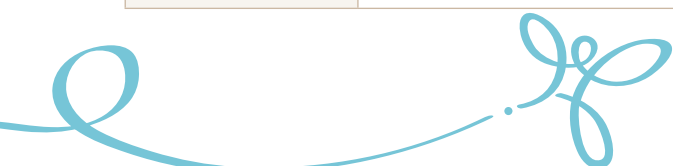
Static (historical) risk factors	Yes (1)	No (0)	Not Known	Dynamic (current) risk factors	Yes (1)	No (0)	Not Known
Recent incidents of violence				Expressing intent to harm others			
Previous use of weapons				Access to available means			
Male				Paranoid ideation about others			
Under 35 years old				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

Assessing clinician's knowledge of consumer's past behaviour/ current clinical presentation

Medical

Police/Ambulance/Other agencies

Other (please specify):

Practitioner GP Details

Address			
Contact Number		Provider Number	

Consumer Details

Height		Weight		Pulse		Blood Pressure		Temperature	
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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	

