Richmind WA

# Residential Accommodation Services Referral Form

## What service would you like to be referred to?

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

Preferred 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)
- 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

- English
- Other:

## Interpreter required

- 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 | |
|---|---|---|---|

## 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)

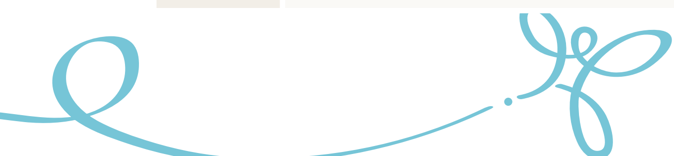
| Name | | Relationship | |
|---|---|---|---|
| Phone | | Mobile | |
| Email | | | |

## 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
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<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 |
|---|---|
| Diabetes | |
| Bruise or bleed easily | |
| Heart complaints | |
| Liver disease | |
| Epilepsy | |
| HIV/AIDS | |
| High or low blood pressure | |
| Speech | |
| Visual | |
| Hearing | |
| Mobility impairments | |
| Respiratory disease | |
| Intersex variation | |
| Other (please state) | |

| Title | Yes |
|---|---|
| Podiatry | |
| Dental | |
| Ulcerations | |
| Asthma | |
| Allergies | |
| Allergic to medication | |
| Acquired head injury | |
| Thyroid problems | |
| Eating disorders | |
| Substance abuse | |
| Women's health screens | |
| Men's health screens | |
| Transgender health screens | |

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?**<br>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 | |

** 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**

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# 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) |
|---|---|---|---|---|---|---|

It takes courage

## Aggregation/Violence

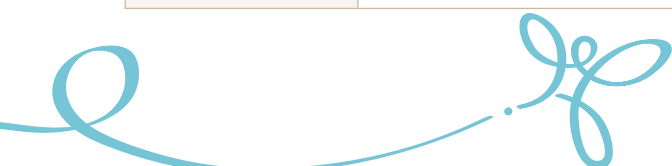
| Static (historical) risk factors | Yes (1) | No (0) | Not Known | Dynamic (current) risk factors | Yes (1) | No (0) | Not Known |
|---|---|---|---|---|---|---|---|
| Recent incidents of violence | | | | Expressing intent to harm others | | | |
| Previous use of weapons | | | | Access to available means | | | |
| 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 | |



Richmind WA

# 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 | |