REFERRAL FORM

~ If you need this Referral Form in Word or Rich Text Format, please contact us on 9842 2612 or email intake@gsaha.org.au ~

Referrals must be completed by a Health Professional or NDIS Support Coordinator.

AHA PROGRAMS AND ELIGIBILITY CRITERIA:

Check eligibility for and tick the requested program/s:

NDIS Support Coordination	NDIS Psychosocial Recovery Coaching	NDIS Support Services
• Aged 18 and over • Are a registered NDIS participant • Have a diagnosed severe and persistent mental health condition **Program requested:** ☐	• Aged 18 and over • Are a registered NDIS participant • Have a diagnosed severe and persistent mental health condition **Program requested:** ☐	• Aged 18 and over • Are a registered NDIS participant • Have a diagnosed severe and persistent mental health condition **Program requested:** ☐
Outreach Individual Community Support	**Outreach Group Activities**	**Transitional Housing**
• Aged 18 – 65 • Are not homeless • Have a diagnosed severe and persistent mental health condition • Receiving ongoing support from WACHS community Mental health, a private psychiatrist or GP • Have low to medium support requirement **Program requested:** ☐	• Aged 18 – 65 • Are not homeless • Have a diagnosed severe and persistent mental health condition • Receiving ongoing support from WACHS community Mental health, a private psychiatrist or GP • Have low to medium support requirement **Program requested:** ☐	• Aged 18 – 65 • Have a diagnosed severe and persistent mental health condition • Receiving ongoing support from WACHS community Mental health, a private psychiatrist or GP • Are homeless, at risk of homelessness or are inappropriately housed and whose needs cannot be met by the wider community **Program requested:** ☐

The referred person must sign their consent to share information with and receive services from AHA Great Southern at the end of this form.

DETAILS OF PERSON BEING REFERRED:

Name	**Last name:**		
	Given names:		
	Preferred name:		
Date of Birth:			
Address:		**Postcode:**	
Telephone/s:	Mobile:	Landline:	
Email:			
Preferred method of contact:	☐ Phone call - mobile ☐ Phone call - landline ☐ Email ☐ Text		
Gender:			
Pronouns:	☐ She/ her ☐ Him/ he ☐ Them/ their		
Country of Birth:			
Do they identify as culturally and linguistically diverse (CaLD)?	☐ Yes ☐ No		
Main language spoken at home:			
Proficiency in spoken English:			
Interpreter required:	☐ Yes ☐ No		
Does the person identify as Aboriginal or Torres Strait Islander?	☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐ Neither ☐ Not stated		
Relationship Status:	☐ Single ☐ Never married ☐ Married ☐ De-facto ☐ Divorced ☐ Separated ☐ Widowed ☐ Prefer not to say		
Dependants:	Number of dependents: _____ Age/s:		
Accommodation:	☐ Own house ☐ Private rental ☐ Public housing ☐ Shared Housing ☐ Homeless ☐ Couch surfing ☐ Hospital ☐ Family/ friends ☐ Correctional facility ☐ Emergency Housing ☐ Other: _____		
Source of income:	☐ Wages ☐ Job Seeker ☐ Disability Support Pension ☐ Other: _____		
Employment:	☐ Full time ☐ Part time ☐ Casual		
Volunteer:	☐ Where: _____ ☐ Days/ hours: _____		
Religion/ spirituality:			

REFERRAL DETAILS

RECOVERY GOALS WITH AHA

Please provide brief reason for referral:	
Preferred areas of recovery	
Willingness to accept support:	
Insight into illness:	
Practical life skills:	
Increase Socialisation:	
Personal Care:	
Budget Management:	
Increase Physical Health:	
Support to maintain housing:	
Hours of support requested:	
Please note person's strengths:	

FOR REFERRALS TO NDIS SERVICES:

NDIS Participant Number:		**NDIS Plan End Date:**	
Managed by:	☐ Self Managed	☐ Agency Managed - Name: Phone:	
NDIS Support Coordinator	**Name:**		
	Organisation:		
	Phone:		
	Email:		
Attached:	☐ NDIS Plan ☐ NDIS Goals		

SUPPORT AVAILABLE TO THE PARTICIPANT

SIGNIFICANT OTHERS AND/OR NEXT OF KIN

Full name:			
Relationship to referred person:			
Address:		**Postcode:**	
Telephone/s:	Mobile:	Landline:	
Email:			
Level of desired contact:	☐ No contact ☐ Emergency only ☐ Full contact		

LEGALLY APPOINTED SUPPORTS

Finances managed by (if not independently):		
Public Trust number (if applicable):		
Legal Guardian (if applicable):	**Name:**	
	Phone:	
	Email:	

MEDICAL SUPPORTS (mark NA if not applicable)

GP	**Name:**	Dr
	Practice:	
	Phone:	
Psychiatrist	**Name:**	
	Practice:	
	Phone:	
	Email:	
Community Mental Health Case Manager	**Name:**	
	Practice:	
	Phone:	
	Email:	

OTHER SERVICES INVOLVED IN THE PERSON'S CARE

Agency:		
Program/ Role:		
Provided by (name):		
Phone/s:		
Email:		

Agency:		
Program/ Role:		
Provided by (name):		
Phone/s:		
Email:		

If not already with NDIS, has NDIS funding been applied for?	☐ Yes – Date: Outcome:
	☐ No – ☐ Not eligible ☐ Not interested

HEALTH

MENTAL HEALTH CONDITION

Diagnosis:			
Date first diagnosed:		**CTO:**	☐ Yes ☐ No
Last hospital admission:	Date:	Length of stay:	
Reason for admission:			
Hospital:			
Medications related to Mental Health: (OR ☐ Medication Record attached)			
Mental Health Decline Warning Signs:			

PHYSICAL HEALTH CONDITIONS

Date of last GP appointment:		**Date of last Physical Health Assessment:**	
Allergies:			
Medical Alerts:		**Diabetes:**	

Does the person experience significant physical pain?	☐ Yes - How is the pain managed? _____ ☐ No
Other Physical Health concerns:	(OR ☐ record attached)
Medications related to Physical Health:	(OR ☐ record attached)

RISK AND PROTECTIVE FACTORS

SUBSTANCE USE

Cigarettes/ Tobacco	**Past:**	
	Current use/ withdrawal:	
Alcohol	**Past:**	
	Current use/ withdrawal:	
Other Drugs – details	**Past:**	
	Current use/ withdrawal:	

SUICIDE AND SELF HARMING RISK ASSESSMENT

Historical Risk Factors	Y	N	NK*	Current Risk Factors	Y	N	NK*
Previous suicide attempts	☐	☐	☐	Expressing suicidal ideas (thoughts)	☐	☐	☐
Previous other self-harm	☐	☐	☐	Has Intent to harm self	☐	☐	☐
Family History of suicide	☐	☐	☐	Has Plan to harm self	☐	☐	☐
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, impulsivity	☐	☐	☐
Loss of job/ retired	☐	☐	☐	Current misuse of drug/alcohol	☐	☐	☐

* Not Known

Protective Factors: e.g. insightfulness, help seeking

AGGRESSION/ VIOLENCE RISK ASSESSMENT

Historical Factors	Y	N	NK*	Current Risk Factor	Y	N	NK*
History of incidents of violence	☐	☐	☐	Current incidents of violence	☐	☐	☐
Previous use of weapons	☐	☐	☐	Expressing intent to harm others	☐	☐	☐
Male	☐	☐	☐	Access to available means	☐	☐	☐
Under 35 years old	☐	☐	☐	Paranoid ideation about others	☐	☐	☐
Criminal history	☐	☐	☐	Violent command hallucinations	☐	☐	☐
Previous dangerous acts	☐	☐	☐	Anger, frustration or agitation	☐	☐	☐
Childhood abuse	☐	☐	☐	Preoccupation with violent ideas	☐	☐	☐
History inappropriate sexual behaviour	☐	☐	☐	Inappropriate sexual behaviour	☐	☐	☐
History of drug/alcohol misuse	☐	☐	☐	Reduced ability to control self/impulsivity	☐	☐	☐
Role instability	☐	☐	☐	Current misuse of drugs/alcohol	☐	☐	☐

* Not Known

Protective Factors: e.g. insightfulness, help seeking

Does the person have any other Vulnerabilities? **E.g.: Self neglect, vulnerability to exploitation/abuse, financial abuse.**
Please indicate and comment:

Are there any concerns or risks you are aware of in relation to the home environment? **E.g.: Hoarding behaviour, pets, unsafe building.**
Please indicate and comment:

AGREEMENT

CONSENT FROM PERSON BEING REFERRED TO SHARE, RELEASE AND GAIN INFORMATION

I, ...,
hereby consent for this referral to be made to AHA Great Southern for services. I hereby authorise staff of the AHA Great Southern to release, obtain and exchange information on my behalf to and from other departments, agencies and parties in relation to my referral for AHA programs as identified in this referral.

SIGN: .....

WITNESS NAME: .....

SIGNATURE: .....

OCCUPATION: .....

DATE: .....

AHA is bound by the Commonwealth Privacy Act (1988) and Amendment (2022) to ensure that your personal information is collected and stored securely.

PERSON MAKING THE REFERRAL – DETAILS.

Name of Referrer:			
Position/Role:			
Organisation:			
Address:			
Phone:		**Email:**	
Date of Referral:			
Are you the Clinical Manager for the person being referred?	☐ Yes ☐ No		

Please check referral information is all completed before sending.

Please email with indicated attachments to: intake@gsaha.org.au