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| **KARRIKIN YOUTH AND WAREKILA ADULT MENTAL HEALTH SERVICE**  **SERVICE PROVIDER REFERRAL FORM** |

**Important Information about your referral:**

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| **Which service is this person being referred to?** |  | Warekila (Adult) | | |  | Karrikin (Youth) | | |
| **Has the person consented to this referral?** | | |  | Yes | |  | No |  |
| **If under 16 years, is a parent/guardian aware of the referral?** | | |  | Yes | |  | No |  |
| If you have answered ‘no’ to the above question, your referral may not be accepted. Please contact us and we’ll talk you through some other options.  Please note that receipt of the referral does not indicate acceptance to Karrikin or Warekila. The suitability of the referral will be determined following review by our Clinicians. If you have any queries about your referral, please contact the office at **(02) 9196 8700** and we can discuss further.  If the client needs urgent assistance, please call the Mental Health Line on **1800 011 511**, dial **000**, or go to the nearest hospital emergency department. | | | | | | | | |

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| **Section 1: APPLICANT DETAILS** | | | | | | |
| First Name: |  | Last Name: | | | |  |
| Gender: |  | Preferred Pronoun(s): | | | |  |
| DOB: |  |  | | | |  |
|  |  |  | | | |  |
| Country of Birth: |  | Parents’ Country of Birth: | | | |  |
| Preferred Language: |  | Language Spoken at Home: | | | |  |
| Interpreter Needed: |  | Interpreter Language: | | | |  |
|  |  |  | | | |  |
| Phone Number: |  | |  | | |  |
| Mobile Number: |  | |  | | |  |
| Email Address: |  | |  | | |  |
|  |  | | | | | |
| Address: |  | | | | | |
| Suburb: |  | Postcode: | |  |

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| **Does the Applicant Identify As:** | | | |
|  | Aboriginal |  | Aboriginal and Torres Strait Islander | |
|  | Torres Strait Islander |  | Neither | |

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| **Marital Status:** | | | |
|  | Never married |  | Separated | |
|  | Married (registered and de facto) |  | Divorced | |
|  | Widowed |  |  | |

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| **Housing** **Status:** | | | |
|  | Owned Home |  | Private Rental | |
|  | Social Housing Aboriginal |  | Boarding House | |
|  | Community Housing |  | Public Housing | |
|  | Emergency Housing |  | Homeless | |

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| **Living Arrangement:** | | | |
|  | Lives with parent(s)/guardian(s) |  | Lives with partner | |
|  | Lives alone |  | Lives with children | |
|  | Lives with other family |  |  | |

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| **Employment Status:** | | | |
|  | Full-time employment |  | Part-time employment | |
|  | Casual employment |  | Studying at school | |
|  | Unemployed |  | Studying at university/TAFE | |
|  | Not in labour force |  |  | |

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| **Income Source:** | | | |
|  | N/A – not in labour force |  | Compensation payments | |
|  | Paid employment |  | Other | |
|  | Disability Support Pension |  | Nil income | |
|  | Other pension or benefit |  |  | |

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| **NDIS Involvement?** | | | | | |
|  | Yes | |  | No |
| Details: | |  | | | | |

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| **Section 2: NEXT OF KIN** | | | | | |
| Full Name: |  | | | | |
| Relationship to Person: |  | | | | |
| Phone Number: |  | | | | |
| Do we have permission to speak to this person? | |  | Yes |  | No |

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| **Section 3: HEALTH INFORMATION** |
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| **Presenting Issues/Reason for referral:**  Please attach any relevant assessment notes, discharge summaries, and/or additional information. |
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| Please list details of primary mental/physical health diagnoses and any other conditions that impact on the applicant’s wellbeing: |
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| **Section 4: CURRENT AND HISTORIC SUPPORT DETAILS** |
| Is the Person currently, or have they previously been, engaged with any of the following: |

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| **Care Provider Type** | **Currently engaged** | **Name** | **Contact Details** |
| General Practitioner | Yes / No |  |  |
| Private Psychologist | Yes / No |  |  |
| Psychologist – Assess Plus or Mental Health Care Plan | Yes / No |  |  |
| Homelessness Provider | Yes / No |  |  |
| Public Mental Health Service | Yes / No |  |  |
| Psychiatrist | Yes / No |  |  |
| Child Protection Agency | Yes / No |  |  |
| Drug and Alcohol Service | Yes / No |  |  |
| Employment Service | Yes / No |  |  |
| Other | Yes / No |  |  |

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| **Section 5: SAFETY CONSIDERATIONS: *Please note these are not exclusion criteria*** |

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| **Suicide?** | |  | Yes |  | No |
| Details: |  | | | | | |
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| **Non-accidental self-injury?** | |  | Yes |  | No |
| Details: |  | | | | | |
|  | |  |  |  |  |
| **Substance use?** | |  | Yes |  | No |
| Details: |  | | | | | |
|  | |  |  |  |  |
| **Past physical or verbal aggression?** | |  | Yes |  | No |
| Details: |  | | | | | |
|  | |  |  |  |  |
| **At risk of homelessness?** | |  | Yes |  | No |
| Details: |  | | | | | |
|  | |  |  |  |  |
| **Risk taking and/or impulsive behaviour?** | |  | Yes |  | No |
| Details: |  | | | | | |
|  |  | | | | | |
| **Non-compliance?** | |  | Yes |  | No |
| Details: |  | | | | | |

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| **Section 6: ADDITIONAL INFORMATION** |

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| Please outline any additional information, history, or anything else you or the applicant would like to add: |
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| **Section 7: REFERRING AGENT DETAILS** |

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| Referring Agent Name: | |  | | |
| Service/Organisation: | |  | | |
| Designation: | |  | | |
| Telephone: |  | | Fax: |  |
| Email: |  | | | |

**Fax: 02 9196 8740**

**If this referral is for the Warekila Adult Mental Health service please email to:** [**snphn.adultmentalhealth@parramattamission.org.au**](mailto:snphn.adultmentalhealth@parramattamission.org.au)

**If this referral is for the Karrikin Youth and Adolescent Mental Health service please email to:** [**karrikin.mentalhealth@parramattamission.org.au**](mailto:karrikin.mentalhealth@parramattamission.org.au)

**The referring agent and applicant will be contacted within 3 business days after receipt of the referral to discuss the next steps.**

***Please note that receipt of the referral does not indicate acceptance to Karrikin or Warekila. The suitability of the referral will be determined following review by our Clinicians.***