WAREKILA ADULT MENTAL HEALTH SERVICE
SERVICE PROVIDER REFERRAL FORM

Important Information about your referral:

Has the person consented to this referral? ☐ Yes ☐ No

If you have answered 'no' to the above question, your referral may not be accepted. Please contact us to discuss further and other possible options.

*If the consumer requires immediate or urgent assistance, please call the Mental Health Line on **1800 011 511**, dial **000**, or attend the nearest hospital emergency department.*

Please note that this form is intended for Service Providers who are involved in the Consumer's care. If you are seeking assistance for yourself, or are a family member or friend wanting to refer your loved one, please contact us directly on **(02) 9196 8700**.

Please be aware that receipt of the referral does not indicate acceptance to the Warekila program, and the suitability of the referral will be determined following review by our team. If you have any queries about your referral, please contact us on **(02) 9196 8700,** or at SNPHN.AdultMentalHealth@parramattamission.org.au

Information on this form will assist our team in determining suitability and with the assessment process. Therefore, please complete with as much information as possible, and provide any supporting clinical documentation available.

Section 1: CONSUMER DETAILS

First Name:		Last Name:	
Date of Birth:		Country of Birth:	
Gender:		Gender Pronoun(s):	
Language Spoken at Home:		Interpreter Language (if required):	
Home Address:			
Suburb:		Postcode:	
Phone Number:		Mobile Number:	
Email:			

Section 2: NEXT OF KIN/EMERGENCY CONTACT DETAILS

Full Name:		Relationship to Consumer:	
Home Address:			
Suburb:		Postcode:	
Phone Number:		Mobile Number:	
Consent to liaise?	☐ Yes	☐ No	

Section 3: HEALTH INFORMATION

Presenting Issues/Reasons for Referral: *Please attach any addition notes, discharge summaries, assessment information*
Primary and Secondary Diagnoses: *Please include any conditions that impact on the Consumer's wellbeing and functioning*

Current Medications/Treatments: *Please provide details*			
☐	Antipsychotics	☐	Antidepressants
☐	Anxiolytics	☐	Psychostimulants and nootropics
☐	Hypnotics and sedatives	☐	Other

Section 4: CURRENT AND PREVIOUS SUPPORTS

Is the Consumer currently, or have they previously been, engaged with any of the following providers?

Warekila routinely works with community GPs to coordinate care and at times, offer telepsychiatry appointments. For this service to be accessible, please ensure the relevant GP information and associated consent is outlined below

Care Provider Type	Please Tick	Name	Contact Details	Consent to Liaise?
General Practitioner				
School Counsellor				
Private Psychologist				
Homelessness Service				
Public Mental Health Service				
Psychiatrist				
Child Protection Agency				
Drug and Alcohol Service				
Employment Service				
Other				

Section 5: DEMOGRAPHICS

Aboriginal and Torres Strait Islander Status	☐	Aboriginal	☐	Torres Strait Islander
	☐	Neither	☐	Both
Marital Status:	☐	Never married	☐	Widowed
	☐	Married (registered de facto)	☐	Separated
	☐	Divorced		
Housing Status:	☐	Sleeping rough or in non-conventional accommodation	☐	Not homeless
	☐	Short-term or emergency accommodation		
Labour Force Status:	☐	Employed	☐	Not in the labour force
	☐	Unemployed		
Employment Participation:	☐	Full-time	☐	N/A – not in the labour force
	☐	Part-time		

Income Source:	☐	N/A – under age 16	☐	Compensation payments
	☐	Disability Support Pension	☐	Nil income
	☐	Other pension or benefit	☐	Not known
	☐	Paid employment	☐	Other
Health Care Card:	☐	Yes	☐	Unknown
	☐	No		
NDIS involvement:	☐	Yes	☐	No
Continuity of Support Client?	☐	Yes	☐	No

Section 6: SAFETY CONSIDERATIONS

Risk of Suicide?	☐ Yes	☐ No
Details:		
Non-Suicidal Self Injury?	☐ Yes	☐ No
Details:		
Substance Use?	☐ Yes	☐ No
Details:		
Physical or Verbal Aggression?	☐ Yes	☐ No
Details:		
At Risk of Homelessness?	☐ Yes	☐ No
Details:		
Risk Taking/Impulsive Behaviours?	☐ Yes	☐ No
Details:		

Section 7: ADDITIONAL INFORMATION

Please outline any additional information, history, or anything else you or the Cosumer would like to add:

Section 8: REFERRING AGENT DETAILS

Name: _____

Service/Organisation: _____

Designation/Profession: _____

Telephone: _____ Fax: _____

Email: _____

How did you hear about our service? _____

Please send the completed referral form to:

Email: snphn.adultmentalhealth@parramattamission.org.au

Fax: **(02) 9196 8740**

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