Mental Health Individual Support Referral Form

Outline of the Service and Referral Criteria

The Individual Support Programs (formerly psychosocial & peer support) provide assistance to people aged 18 years and over with a serious and persistent mental health challenge living in the Swan and North Metropolitan Health service area.

- Individuals can be in a range of accommodation settings, including community housing, private rentals, own homes, hostels and alternate living arrangements;
- They must have guaranteed on-going clinical support;
- They must require support to live successfully in the community – the range of supports is outlined below.
- *This referral is to be completed by one of the treating Clinical Supports: Psychologist, Social Worker, Mental Health Clinic, Psychiatrist or a General Practitioner.*

The support services provided will be based on an assessment of the needs of the individual and could include:

- Social networks, friendships, social skills
- Family connections
- Financial management, budgeting, bill payment
- Tenancy maintenance and support
- Contribution through volunteering or work
- Training and education
- Peer support
- Services for general health and well-being; physical activity, specialist appointments or drug and/or alcohol support
- Life skills development; confidence, self-esteem and resilience

Does the client have support needs that fit with the above? Yes ☐ No ☐
If the answer is YES then proceed with the application and please ensure (where possible) that the client signs the referral form on page 7. **Please complete all sections of this form.**

Please return the referral to;
Via email to; rebecca.fitzpatrick@risenetwork.com.au
Via fax to; 92740609
Or post to; 1/14 Stafford Street, Midland WA 6056

If you would like any further information, please contact Service Coordinator for Mental Health, Rebecca Fitzpatrick on;

Via mobile; 0447855693

Via landline; 62743756

Client, Clinical Support and Referee's Details

Referred By:	**Client Details:**
Name:	Name:
Address:	Address:
Post Code:	Post Code:
Phone Number:	Phone Number:
Mobile:	Mobile:
Email:	Date of Birth:
	Mental Health Diagnosis:
GP Details	**Psychiatrist/ Psychologist/Other**
Name:	Name:
Surgery:	Clinic:
Address:	Address:
Post Code:	Post Code:
Phone Number:	Phone Number:

Does the client have a Carer or Guardian? Yes ☐ No ☐ If yes, please complete:

Name : _____ Agency Name : _____

Contact No : _____ Email : _____

Has this person received support from another agency or are they currently receiving support from another agency? Yes ☐ No ☐

If yes, please give details of agency involvement, support date/s and indicate why a referral is being made to this service:

What are the key objective(s) to involving the Individual Support team for this client?

Referrer:

Client:

Does the client have any children/dependents?

Name:	**D.O.B**	**Relationship:**	**Living with the client?**
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐

Housing

Is the client in Public or Private housing? Public ☐ Private ☐

Does the client currently have or previously had a tenancy agreement? Yes ☐ No ☐

If yes, please give the address details and current landlord details:

If no, please proceed to Housing History.

Does the client have any behaviours that might impact accommodation types? Yes☐ No ☐
If yes, please give details of current and previous issues: *(ASBO's, Neighbour issues, nuisance etc.)*

Housing History

Please provide a brief housing history for the past 5 years (starting with the current)

Period / time	Address	Tenure and type of accommodation *(Rented, Owned, Hostel, Long Term Hospital stay / other)*

Other details/information relevant to their housing situation:

Finances

(Please mark as appropriate and give details where required)

The client is:
In receipt of a pension: Yes ☐ No ☐ Pension Type: _____ CRN No: _____
In receipt of rent assistance: Yes ☐ No ☐
In receipt of any other form of a welfare benefits: Yes ☐ No ☐
Does the client receive any other form of income? Yes ☐ No ☐

If Yes, please give details: _____

Does the client have any debts? Yes ☐ No ☐

If Yes, please give details:

Debt Details:	
Rent Arrears	Yes ☐ No ☐
Utilities: Gas / Water	Yes ☐ No ☐
Electricity	Yes ☐ No ☐
Loan/s	Yes ☐ No ☐
Fine: Court / Parking	Yes ☐ No ☐
Other	Yes ☐ No ☐

Health Issues

What is your view of the client's **Physical Health**. Does the client suffer from any long term physical illness / disability? Yes ☐ No ☐

Please specify details and any agencies working with the client:

On occasion, the Individual Support worker may incorporate physical activity into the support plan for the individual, for the associated benefits to both physical and mental health. The following information, helps staff determine whether this would be suitable:

Health:	
BMI:	
Smoker Status:	Yes ☐ No ☐ If yes, how many cigarettes per day:
Other Health Considerations:	Diabetes: Yes ☐ No ☐
	Poor diet: Yes ☐ No ☐
	Minimal physical activity: Yes ☐ No ☐
	High/ Low Blood Pressure: Yes ☐ No ☐
	High Cholesterol: Yes ☐ No ☐
	Other:

Does the client have any restriction in their ability to participate in physical activity:
Yes ☐ No ☐
If yes, the client's GP may be required to complete a medical clearance form if physical activity is to be included in their support plan.

Please outline the client's **Mental Health** condition:

Does the client have a history of self-harm? Yes ☐ No ☐
If Yes, please specify details and agencies working with client:

Drug and Alcohol Use:

Does the client have any issues with drug and/or alcohol use: Yes ☐ No ☐
If Yes, please give details:

Has the client engaged with a drug and/or alcohol support service? Yes ☐ No ☐
If Yes, please give details:

Other Information:

Does the client have a criminal record? Yes ☐ No ☐
If you answered yes, please identify:

Does the client have current or previous issues with any of the following?
Please tick as appropriate:

Details:	Yes	No
Basic Living Skills		
Budgeting / Debt		
Gambling / Addiction		
Domestic Violence or Abuse		
Violence / Aggression		
Other - please specify		

Any other information required for the above areas?

Given that outreach visits are a key part of the support provided for clients, please give full consideration to the following question.

Would you consider lone visits to pose a significant risk? Yes ☐ No ☐
Please give details:

Additional information

Do you have any additional information, comments or details for the referral of this client?

Thank you for taking time to complete this Referral form. Please ensure all sections are complete and sign the confirmation of correct information and details of such below.

Signature Referring Agent:

Signature Client:

Date: