Community Mental Health Programs Referral Form

*To be completed by referrer (self-referrals accepted). Complete all sections of this form and return this form to* *referrals@richmondtas.com.au**. For more information, please contact 03 6228 3344.*

|  |  |
| --- | --- |
| **Has the Participant given consent to share their information with us?** | [ ]  Yes [ ]  No |
| **This referral is for program:**  | [ ]  Outreach [ ]  MHHOP |

|  |  |  |  |
| --- | --- | --- | --- |
| **Participant Name:** |  | **Date of birth:** |  |
| **Email:** |  | **Phone:** |  |
| **Address:** |  |
| **Gender:** | [ ]  Male  | [ ]  Female  |  | **Preferred Pronouns:** |  |
|  | [ ]  Other:  |  |  | **Identifies as LGBTQIA+:** | [ ]  Yes [ ]  No |

|  |  |  |  |
| --- | --- | --- | --- |
| **Cultural background:** |  |  | **Aboriginal or Torres Strait Islander Origin:** |
| **Preferred language:** |  |  | [ ]  Yes, Aboriginal | [ ]  No |
| **Requires interpreter:** | [ ]  Yes [ ]  No |  | [ ]  Yes, Torres Strait Islander |
| **Mental health diagnosis:** |  |

| **Reason for referral** |  |
| --- | --- |
|  |

| **Previous mental health history** |  |
| --- | --- |
|  |

| **Other health needs that we need to be aware of** |  |
| --- | --- |
|  |

| **Risk Assessment** |  |
| --- | --- |
| [ ]  | No known risks | [ ]  | Risk of self-harm / injury |
| [ ]  | Risky behaviours that put themselves/others in danger | [ ]  | At risk of abuse by others (physical / sexual / emotional / financial) |
| [ ]  | History of verbal/physical aggression  | [ ]  | Other: |  |
| [ ]  | Suicidal thoughts / ideation ***(if you tick this, please complete with participant)*** |
| 1. **In the past month**, have you wished you were dead or wished you could go to sleep and not wake up?
 | [ ]  Yes [ ]  No |
| 1. **In the past month,** have you had any thoughts about killing yourself?

***(if you tick YES, please answer below)*** | [ ]  Yes [ ]  No |
| Have you been thinking about how you might do this? | [ ]  Yes [ ]  No |
| Have you had some intention of acting on these thoughts? | [ ]  Yes [ ]  No |
| Have you started to work out on the details of how to kill yourself? Did you intend to carry out this plan? | [ ]  Yes [ ]  No |
| 1. **In your lifetime,** have you done anything, started to do anything, or prepared to do anything to end your life?
 | [ ]  Yes [ ]  No |
| 1. **In the past 3 months**, have you done anything, started to do anything, or prepared to do anything to end your life?
 | [ ]  Yes [ ]  No |
| **The risk rating is** | [ ]  | Low | [ ]  | Medium | [ ]  | High |

***We are not a crisis service and is unable to support participants who are actively suicidal. Acceptance of this referral will be based on participant’s suicide risk assessment at the initial meeting.***

# Carer / Emergency Contact Details

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Relationship:** |  |
| **Email:** |  | **Phone:** |  |

# Other Stakeholders *If applicable, please provide details of participant’s stakeholders.*

| **Role / organisation** | **Name** | **Contact details** |
| --- | --- | --- |
| General Practitioner |  |  |
|  |  |  |

# Referrer Details (if not self-referred)

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Relationship:** |  |
| **Email:** |  | **Phone:** |  |
| **Address:** |  | **Organisation:** |  |
| **Signature:** |  | **Date:** |  |