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*](mailto: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:** |  |