TasRec 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 |

# Participant Details

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 / goals:** | | | | |  | | | | | |
|  | | | | | | | | | |

| **Background Information** *(tick all that are relevant to the Participant)* | | |
| --- | --- | --- |
| Chronic / long term illness | | Social isolation / loneliness |
| Migrant / refugee | | Trauma / bereavement |
| Homelessness (at risk of, or history of) | | Victim / survivor of abuse or neglect |
| Has a disability (physical, cognitive, intellectual / sensory) | | |
| Other. Please specify |  | |
| **Notes:** | | |
|  | | |

| **Medical Information** | |  |
| --- | --- | --- |
| No other chronic health risks | Asthma | Epilepsy |
| Diabetes (1 or 2) | Anaphylaxis | Heart disease |
| High blood pressure | Other. Please specify: |  |
| ***Are you prescribed medication to use in an emergency?*** | Yes. Please specify: |  |
| No |  |
| **Notes:** | | |
|  | | |

| **Food Allergies** | |  |
| --- | --- | --- |
| No food allergies | Peanuts | Soy |
| Fish/shellfish | Dairy | Gluten |
| Eggs | Other. Please specify: |  |

| **Dietary Preferences** | |  |
| --- | --- | --- |
| No food preferences | Vegetarian | Vegan |
| Pescatarian | Gluten Free | Lactose Free |
| Low FODMAP | Kosher |  |
| Halal | Other. Please specify: |  |
| **Notes:** | | |
|  | | |

| **Risk Assessment** | | | | | |  | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | No known risks | | | | | |  | | Self-neglect | | | |
|  | Active substance misuse | | | | | |  | | Loss of employment / housing / family | | | |
|  | Risky behaviours that put themselves in danger | | | | | |  | | Risky behaviours that put others in danger | | | |
|  | History of abusing / neglecting others in their care | | | | | |  | | At risk of abuse by others (physical / sexual / emotional / financial) | | | |
|  | History of verbal or physical aggression towards others | | | | | |  | | History of committing sexual assault, harassment, stalking | | | |
|  | History of property damage / arson | | | | | |  | | 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.***

# Program Preferences

*Which program(s) are you interested in? You can select more than 1. If the classes you selected is full, you will be placed on a waitlist and offered alternatives.*

|  |  |  |
| --- | --- | --- |
| **South Classes:** | | |
| Open Arts | ***Below classes involves physical activities:*** | |
| Social Group | Just Move | Yoga |
| Cooking | Walking Group | Hanging with Horses |
| **North Classes:** | | |
| Open Arts | Creative Arts | Cooking |
| Arts and Crafts | Social Group / Day Trip |  |
| **Northwest Classes:** | | |
| Cooking | Social Group / Day Trip | Just Move (involve physical activities) |

# Physical Activity Readiness Questionnaire (PAR-Q)

|  |  |
| --- | --- |
| Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by them? | Yes  No |
| Do you feel pain in your chest when you perform physical activity? | Yes  No |
| In the past month, have you had chest pain when you were not doing any physical activity? | Yes  No |
| Do you lose your balance because of dizziness, or do you ever lose consciousness? | Yes  No |
| Do you have a bone or joint problem that could be made worse by a change in your physical activity? | Yes  No |
| Is your doctor currently prescribing any medication for your blood pressure or heart condition? | Yes  No |
| Do you know of any other reason why you should not engage in physical activity? | Yes  No |

***If you answered YES to one or more questions, you must consult a doctor and obtain medical clearance that includes any information about specific exercise limitations or guidelines.***

*It is important to start exercising slowly and increase intensity gradually. If you’re feeling unwell, talk to your doctor before joining the program.*

# Carer / Emergency Contact Details

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

# Other Stakeholders

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

| **Role / organisation** | **Name** | **Contact details** |
| --- | --- | --- |
| Adult Mental Health |  |  |
| Forensic Mental Health |  |  |
| Guardian |  |  |
| Public Trustee |  |  |
| NDIS |  |  |
|  |  |  |

# Referrer Details (if not self-referred)

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

# Participant Consent

I acknowledge and understand that by signing this form, I am giving permission for my information to be shared, read, and discussed by my referrer and Richmond Futures employees.

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature:** |  | **Date:** |  |
| **Name:** |  |  |  |