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**. 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:** |  |  |  |