St Bart's

REFERRAL FORM - MENTAL HEALTH SERVICES

This Referral Form is for **St Bart's Mental Health Services.** It should be completed with the applicants consent and, ideally, in the presence of. Please ensure all sections are completed, with the relevant supporting documents attached, before sending it to **MHreferrals@stbarts.org.au.**

Please note incomplete or illegible referrals will be returned, resulting in processing delays. Referrals will also be deemed incomplete until all of the applicable information has been received.

REFERRERS DETAILS

Referrers Name:	**Date of Referral:** / /
Organisation:	**Position:**
Email:	**Phone:**

ST BART'S MENTAL HEALTH SERVICES

Please ensure your read the eligibility criteria before referring to any of these services.

Which service/s are you applying for (tick all that apply)

- ☐ Arnott Community Recovery Village (Kelmscott)
- ☐ Bentley Community Recovery Village
- ☐ Sunflower Community Recovery Village (Stirling)
- ☐ Swan Community Recovery Village (Mid- Swan)
- ☐ Cannington Accommodation Unit
- ☐ Medina Accommodation Unit
- ☐ Midland Accommodation Unit

Please note we only accept referrals for our Mental Health Services when we have a vacancies.

SUPPORTING DOCUMENTS

Please include the following information with your referral (if applicable):

- ☐ Treatment, support discharge plan *
- ☐ PSOLIS alerts (if applicable)*
- ☐ Current National Disability Insurance Scheme [NDIS] Plan (if applicable)
- ☐ Risk Assessment and Management Plan completed by a clinician*
- ☐ Recent Discharge Summaries (if applicable)
- ☐ Community Treatment Order [CTO](if applicable)*
- ☐ Physical Health Assessment completed by a Doctor / General Practitioner*
- ☐ Forensic history including any current legal issues (e.g. orders, upcoming court dates)

** These documents are mandatory*

APPLICANTS DETAILS

First Name: **Surname:**

Preferred Name: **Date of Birth:** / /

Preferred Pronouns:

Full Address: **Postcode:**

Email: **Phone:**

Gender: ☐ Male ☐ Female ☐ Agender ☐ Gender Diverse
☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Other:

Do you identify as LGBTIQA+: ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say

Aboriginal: ☐ Yes ☐ No ☐ Prefer not to say **Torres Strait Islander:** ☐ Yes ☐ No ☐ Prefer not to say

Culturally and Linguistically Diverse: ☐ Yes ☐ No ☐ Prefer not to say

Main language spoken: ☐ English ☐ Other:_____ **Country of Birth:**

Interpreter required: ☐ Yes ☐ No **English Proficiency**: **Visa status:**

Marital Status: Never Married ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ **Defacto** ☐

FINANCE

Source of income: ☐ Age Pension ☐ Youth Allowance
☐ Disability Support Pension ☐ Paid Work
☐ Newstart Allowance / JobSeeker Other: _____

Do you hold a Department of Veterans' Affairs [DVA] Health Card: ☐ Yes ☐ No

Centrelink Customer Reference Number (CRN): **Expiry:**

Medicare Number: **Expiry:**

HOUSING

Have you stayed at St Bart's before: ☐ Yes ☐ No **If yes, when:**

Housing History:

Current living situation: ☐ Privately owned ☐ With friends ☐ Hospital ☐ Rental
☐ Supported ☐ Homeless ☐ With carer / family ☐ Hostel ☐ Other: _____

Are you on the housing waitlist: ☐ Yes ☐ No **Are you priority listed:** ☐ Yes ☐ No

Are you on the By-Name's list: ☐ Yes ☐ No

CONTACTS

Name of Next of Kin or Nominated Support Person: **Relationship:**

Email: **Phone:**

Do you have a Clinical Case Manager: ☐ Yes ☐ No **Name:**

Email: **Phone:**

Do you have a Guardian: ☐ Yes ☐ No **Name:**

Email: **Phone:**

Do you have a Public Trustee: ☐ Yes ☐ No **Name:**

Email: **Phone:**

Do you have a DCPFS Case Worker: ☐ Yes ☐ No **Name:**

Email: **Branch:** **Phone:**

Do you have a Community Corrections Officer: ☐ Yes ☐ No **Name:**

Email: **Location:** **Phone:**

Other Support Person / Service (e.g. NDIS, Carer, Silverchain etc.)**:** **Name:**

Email: **Phone:**

DISABILITY

Do you have a Disability, Please specify ☐ N/A

Do you have a current NDIS Plan: ☐ Yes ☐ No *If yes, please include a copy of the plan*

Do you have any current support from a Disability service (e.g. Silverchain etc.)**:** ☐ Yes ☐ No

Details:

PHYSICAL HEALTH

Any physical health conditions: ☐ Yes ☐ No e.g heart complaint, hepatitis, HIV, recent fall, ABI, pregnant

Details:

MENTAL HEALTH

If you have a Mental Health diagnosis, please specify: ☐ N/A

Are you under the care of a Community Mental Health Service: ☐ Yes ☐ No ☐ Yes, once discharged

If applicable please provide a copy of the Client Management Plan, Risk Assessment Management Plan & PSOLIS alerts

If you ticked yes, please specify which area / team:

Are you on a Community Treatment Order [CTO]: ☐ Yes ☐ No *(Please provide CTO)*

Any hospital admissions in the last 12 months: ☐ Yes ☐ No *(Please provide Discharge Summary)*

If yes, provide details of admission (reason, dates etc):

DRUG AND ALCOHOL USE

Do you have a history or are you currently using drugs and/or alcohol: ☐ Yes ☐ No

If yes, please provide details of drug(s) of concern, frequency, amount, history of use:

Are there any associated risks, behaviours or problems: *(e.g. Aggression, Hepatitis, injecting, overdose)*: ☐ Yes ☐ No

If yes, please provide details:

Are you currently accessing support around your substance or alcohol use: ☐ Yes ☐ No

If yes, please provide details:

LEGAL ISSUES

Do you have any <u>past</u> or <u>current</u> legal issues: ☐ Yes ☐ No

(e.g. Community orders / pending court dates / prison history)**:**

if <u>yes</u> please provide a copy of forensic history including any current legal issues (e.g. orders, upcoming court dates)

Provide details:

If being referred from prison, please answer these questions:

Prison location:	**Time length in prison:**
Full sentence date:	**Convictions** (include above)
Are you applying for Parole: ☐ Yes ☐ No	**If yes, Parole date:**
Have you been assigned a Community Corrections Officer: ☐ Yes ☐ No	

SUPPORT NEEDS

Are there any particular tasks you find challenging and require additional support with:
(e.g cooking, cleaning, personal care, medication etc)

ADDITIONAL

Is there any additional information we need to know:

SIGNED CONSENT

I acknowledge the information provided is correct and true. I agree that St Bart's may contact my health/community services or my contacts provided to gather additional information to assist with my referral, if needed.

I consent to my referral being submitted for consideration of the selected St Bart's Homeless Service.

Application name: **Date: / /**

Signature:

If the applicant has a state appointed Guardian, they must additionally sign :
(referrals will not be processed until signed)

Guardian name: **Date: / /**

Signature:

Please note we only accept referrals when we have a vacancy.

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Completed referrals and all supporting documents are to be emailed to MHreferrals@stbarts.org.au