Top End Association for Mental Health -Respite Referral Form

TEAMhealth provides:
Recovery focussed psychosocial rehabilitation programs for people and their families affected by mental illness. For further program information please refer to the TEAMhealth brochure or contact the program Team Leader / Manager.

Service request (please tick one or more boxes)

Respite Program Planned flexible respite options for carers caring for a person with a mental illness.

Service Area ❑ Top End ❑ Central Australia

Carer Details:

Name:	DOB:	Gender: ❑ Male ❑ Female ❑ Other
Address:	Telephone: Mobile:	
Indigenous status: ❑ Aboriginal not Torres Strait Islander ❑ Torres Strait Islander not Aboriginal ❑ Both Aboriginal and Torres Strait Islander ❑ Not Indigenous	Country born: Primary language spoken:	Interpreter required: ❑ Yes ❑ No
Current Health Issues/Diagnosis:		

Care Recipient Details:

Name:	DOB:	Gender: ❑ Male ❑ Female ❑ Other
Address:	Telephone: Mobile:	
Indigenous status: ❑ Aboriginal not Torres Strait Islander ❑ Torres Strait Islander not Aboriginal ❑ Both Aboriginal and Torres Strait Islander ❑ Not Indigenous	Country born: Primary language spoken:	Interpreter required: ❑ Yes ❑ No

Current Health Issues/Diagnosis: (NB the care recipient must have a primary diagnosis of a mental illness TEAMhealth does not provide service to children with Pervasive Developmental Disorders).

TEMHS or CAMHS Case Manager name:	Telephone:
GP Name and Clinic:	Telephone:
Other Support/s:	Telephone:

Person referring or referral agent details

❑ I confirm / consent that the carer and care recipient have consented to this referral for service from TEAMhealth– *(please note that a referral cannot be accepted without a person's consent)*

Carer name: Care recipient name:	Signature/s:	Date:
Referrers position title & Organisation:	Signature:	Date:
Email address:	Telephone:	Fax number:

Please provide as much information as possible regarding to assist with the assessment process. Please include additional information if required and attach separate document/s. N.B. This checklist must be completed for TEAMhealth to accept the referral *(please tick all relevant boxes).*

Mental health status: ❑ Current diagnosis ❑ HE2ADS3 *(youth psychosocial screening tool)* ❑ GP Mental Health Plan ❑ Previous psychiatric history/presentations ***For TEMHS & CAMHS Teams only:*** ❑ Current care plan (ICP) ❑ Triage assessment ❑ Hospital Discharge Summary ❑ Relapse Prevention Plan ❑ Mental State Examination *(including level of insight)* ❑ Risk assessment (RATT) ❑ Current HoNOS *(Health of the Nation Outcome Survey)* ❑ Nursing discharge and/or follow up letter ❑ Life Skills Profile (LSP)	Additional documentation attached ❑
Drug and/or alcohol: ❑ History, current use ❑ Impact current use has on lifestyle ❑ Treatment interventions ❑ Engaged with AOD services	Additional documentation attached ❑
Medication management and support: ❑Medication Management Plan **NB:** *All clients who require assistance from TEAMhealth staff with medication management must have a medication management plan prepared by a clinical service provider i.e. GP or Government Mental Health Service before a referral can be accepted.* ❑ Prescribed medication used including PRN ❑ Support and management issues ❑ Dose administration aids used ❑ Compliance ❑ Effectiveness ❑ Side effects.	Additional documentation attached ❑
Physical illness: ❑Epilepsy ❑ Asthma ❑ Heart Disease ❑Diabetes ❑ Allergies ❑ Infectious diseases such as Hepatitis ❑ Mobility issues ❑ Nutrition or vitamin deficiencies ❑ Other *(please specify)*	Additional documentation attached ❑
Legal issues: ❑ Guardianship Order ❑ Community Management Order (CMO) ❑ Pending criminal proceedings ❑ Relevant criminal history ❑ Family and Children's Services (FACS) involvement	Additional documentation attached ❑
Risk issues: ❑History of aggressive behaviour ❑Previous risk to self and others, including staff ❑ Current Behavioural Management Plan	Additional documentation attached ❑
Housing situation: ❑Homeless ❑ SAAP agency ❑ Hostel ❑ Private rental ❑ Territory Housing ❑ Other *(please specify)* For people applying for TEAMhealth housing or residential programs: ❑ Previous tenancy issues – e.g. debts from previous tenancies, ❑ able to share with others.	Additional documentation attached ❑
Supports and skills assessment: ❑ Family/friends support available – e.g. parents, siblings, spouse, other close relatives, friends ❑ Involvement in community ❑ Education level ❑ Literacy and numeracy.	Additional documentation attached ❑

Any other special needs / reason for referral:

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Darwin Office:	**Ph:** 08 8943 9600	**Fax:** 08 8943 9601	PO Box 4050 Darwin NT 0801
Katherine Office:	**Ph:** 08 8971 3344	**Fax:** 08 8971 0904	PO Box 1177 Katherine NT 0850
Alice Springs Office:	**Ph:** 08 8953 4193	**Fax:** 08 8952 0959	PO Box 4144 Alice Springs 0870