

TEAMhealth provides:

Recovery focused psychosocial rehabilitation programs for people over the age of 16yrs and their families affected by mental illness. For further program specific information please refer to the TEAMhealth brochure. To enquire about a referral to each program please speak to the program Team Leader or Manager.

Darwin office Ph: 08 8943 9600 **Fax:** 08 8943 9601 **Katherine office Ph:** 08 8971 3344 **Fax:** 08 8971 0904

Alice Springs office Ph: 08 8953 4193. **Fax:** 08 8952 0950

Service request (Please tick one or more boxes)

- Community Housing Program (CHP)** – Supported housing program in Darwin and Palmerston. Shared and non-shared, medium to long-term options for people 18-64yrs.
 - Day to Day Living Program (D2DL)** – Drop In and Day Program based in Rapid Creek Darwin providing outreach to access the program to Palmerston. **Ph:** 08 8943 9600
 - Family and Youth Service (FAYS)** – Education and support for young people (16-24) and families in the Top End.
 - Mental Health Respite Program (MHRP)** – Planned flexible respite for carers in the Top End and Alice Springs.
 - Manse** – 24hrs supported long term accommodation in Darwin for people 18-64yrs.
NB: Referrals accepted from Top End Mental Health Services only. **Ph:** 08 8981 8417 **Fax:** 08 8981 6037
 - Personal Helpers and Mentors Program (PHaM)** - Outreach support for people who may or may not, be engaged with clinical services and/or, are not currently engaged in any other service. Top End Rural and Remote.
 - Recovery Assistance Program (RAP)** – Outreach support Darwin and Palmerston and Katherine for people 18-64yrs.
 - Sub Acute Program** – intensive residential and outreach support for up to 4 weeks. For people aged 16-64.
 - Papaya – 24/7 residential. Community outreach program servicing Darwin and Palmerston.
- NB:** Referrals accepted from Top End Mental Health Services only. **Ph:** 08 8948 0501 **Fax:** 08 8948 4610

Details of the person for whom the referral is being made

| | | | |
|--|---|-----------------------------|---|
| Name: | | Ph: | |
| Current address: | | Country of birth: | |
| GP Name: | Religion: | Cultural Background: | |
| Primary language: | Interpreter required: <input type="checkbox"/> Yes <input type="checkbox"/> No | DOB: | Postcode: Mobile: |
| Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | Current Case Manager: <input type="checkbox"/> Yes <input type="checkbox"/> No | Preferred name: | Indigenous status: Aboriginal not Torres Strait Islander <input type="checkbox"/> Torres Strait Islander not Aboriginal <input type="checkbox"/> Both Aboriginal and Torres Strait Islander <input type="checkbox"/> Not Indigenous <input type="checkbox"/> |
| Case Manager name: | | Case Manager Ph: | |

Carer details and dependant info

| | | |
|--|---|---|
| Carer name: | Primary language spoken: | Interpreter required: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Carer address: | Telephone: | DOB: Mobile: |
| Religion: | Does the person have any dependant children in their care? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes name and age?) → | 1. Full name: DOB: |
| HRN no: | | 2. Full name: DOB: |
| Is the person currently in receipt of any other services? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes what services?)↓ <input type="checkbox"/> GP <input type="checkbox"/> Psychologist <input type="checkbox"/> FACS <input type="checkbox"/> TEMHS <input type="checkbox"/> CAMHS <input type="checkbox"/> Somerville <input type="checkbox"/> Anglicare <input type="checkbox"/> Centacare <input type="checkbox"/> Danila Dilba <input type="checkbox"/> other please specify: | | 3. Full name: DOB: |
| | | 4. Full name: DOB: |
| Current (Primary diagnosis): | | Additional diagnosis: 1. 2. |

Who diagnosed the mental illness? GP Private Mental Health Practitioner e.g. Private Psychiatrist
 Top End Mental Health Service (TEMHS) or Central Australia Mental Health Services (CAMHS)
 ICD-10 Code: _____ (For TEMHS and CAMHS staff only)

Reason for referral:

Referrals must include all relevant information as indicated below. Please provide as much information as possible to assist with the assessment process. Where referrers wish to include additional information please attach a separate documents as required (please tick all relevant boxes).

| | |
|--|---|
| <p>Mental health status: <input type="checkbox"/> Current diagnosis <input type="checkbox"/> Info on most recent episode or hospitalisation <input type="checkbox"/> HE2ADS3 – (youth psychosocial screening tool) <input type="checkbox"/> GP Mental Health Plan <input type="checkbox"/> Previous psychiatric history/presentations For TEMHS & CAMHS Teams only: <input type="checkbox"/> Current care plan (ICP) <input type="checkbox"/> Triage assessment <input type="checkbox"/> Hospital Discharge Summary <input type="checkbox"/> Relapse Prevention Plan <input type="checkbox"/> Mental State Examination (including level of insight) <input type="checkbox"/> Risk assessment (RATT) <input type="checkbox"/> Current HoNOS (Health of the Nation Outcome Survey) <input type="checkbox"/> Nursing discharge and/or follow up letter</p> | <p>Additional documentation attached <input type="checkbox"/></p> |
| <p>Drug and/or alcohol: <input type="checkbox"/> History, current use <input type="checkbox"/> Impact current use has on lifestyle & treatment interventions <input type="checkbox"/> Date of last or if a referral has been made to an AOD service <input type="checkbox"/> Recent AOD assessment <input type="checkbox"/> Insight re impact of use.</p> | <p>Additional documentation attached <input type="checkbox"/></p> |
| <p>Medication management and support: <input type="checkbox"/> 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. <input type="checkbox"/> Prescribed medication used including PRN <input type="checkbox"/> Route of administration <input type="checkbox"/> Support and management issues <input type="checkbox"/> Dose administration aids used <input type="checkbox"/> Compliance <input type="checkbox"/> Effectiveness <input type="checkbox"/> Side effects.</p> | <p>Additional documentation attached <input type="checkbox"/></p> |
| <p>Physical illness: <input type="checkbox"/> Epilepsy <input type="checkbox"/> Asthma <input type="checkbox"/> Heart Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Infectious diseases such as hepatitis <input type="checkbox"/> Nutrition or vitamin deficiencies <input type="checkbox"/> Mobility issues <input type="checkbox"/> Allergies <input type="checkbox"/> Other (please specify)</p> | <p>Additional documentation attached <input type="checkbox"/></p> |
| <p>Legal issues: <input type="checkbox"/> Guardianship Order <input type="checkbox"/> Community Management Order (CMO) <input type="checkbox"/> Pending criminal proceedings <input type="checkbox"/> Relevant criminal history <input type="checkbox"/> Family and Children’s Services (FACS) involvement</p> | <p>Additional documentation attached <input type="checkbox"/></p> |
| <p>Risk issues <input type="checkbox"/> History of aggressive behaviour <input type="checkbox"/> Previous risk to self and others, including staff <input type="checkbox"/> History of verbal or physical aggressive behaviour <input type="checkbox"/> Current Behavioural Management Plan</p> | <p>Additional documentation attached <input type="checkbox"/></p> |
| <p>Housing situation: <input type="checkbox"/> Homeless <input type="checkbox"/> SAAP agency <input type="checkbox"/> Hostel <input type="checkbox"/> Private rental <input type="checkbox"/> Territory Housing <input type="checkbox"/> Other (please specify) For people applying for a TEAMhealth housing service or the Sub Acute Residential: <input type="checkbox"/> Previous tenancy issues – e.g. debts from previous tenancies, <input type="checkbox"/> able to share with others.</p> | <p>Additional documentation attached <input type="checkbox"/></p> |
| <p>Supports <input type="checkbox"/> Family/friends support available – e.g. parents, siblings, spouse, other close relatives, friends, <input type="checkbox"/> involvement in community <input type="checkbox"/> Education level <input type="checkbox"/> Literacy and numeracy.</p> | <p>Additional documentation attached <input type="checkbox"/></p> |
| <p>Any other special needs: _____</p> | |

Person referring or referral agent details

I confirm that the person has consented to this referral for service from TEAMhealth - (please note that a referral cannot be accepted without a person’s consent)

Signature of referrer: _____

| | | | |
|-------------------------------------|--|-------------|--|
| Name and title of person referring: | | Date: | |
| Name of organisation: | | Telephone: | |
| Email address: | | Fax number: | |

I understand and agree to this referral. I understand that TEAMhealth works in partnership with other services. By signing this referral I agree to let the following services exchange information relevant to my care. (Please tick)

Top End Mental Health Services (TEMHS) and/or Central Australian Mental Health Services (CAMHS) My GP Private Psychiatrist Psychologist Corrections Northern Territory Police Other (please specify)

Signature of person being referred: _____