Community Housing Service (CHS) Referral Form

Team HEALTH
Supporting your mental health journey

TeamHEALTH actively promotes and supports an inclusive and diverse culture. We welcome all people, regardless of age, gender, race, ability, sexual orientation, faith, religion and all other identities represented in our community.

Our Community Housing Service offers stable and affordable housing for eligible people living with mental health conditions, across Darwin and Palmerston. We offer medium to long-term accommodation in a range of units and houses. This is longer-term housing rather than crisis or emergency accommodation: a settled base for people ready to live independently in the community.

Participant Details

Participant's Name: _____ Preferred Name: _____

Date of Birth: _____ Country of Birth: _____

Gender Identity: ☐ Woman ☐ Man ☐ Non-binary

☐ Different term – please specify: _____

Pronouns (optional): _____

Address: _____

Email Address: _____ Phone Number: _____

Preferred language: _____

(The language the participant feels most comfortable using).

Interpreter needed? ☐ No ☐ Yes If yes, what language? _____

Any other language or communication supports needed? ☐ No ☐ Yes

If yes, please describe: _____

(For example: Auslan, large print, a communication device, or support person)

Is the participant of Aboriginal and/or Torres Strait Islander origin? ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander

(Select both Yes options if this applies to you)

Cultural identity (optional): _____

(How would you describe your cultural identity or background? For example, your heritage, community or cultural group?)

Public Guardian in Place? ☐ No ☐ Yes *Name & Phone Number:* _____

Carer in Place? ☐ No ☐ Yes *Name & Phone Number:* _____

Case Manager in Place? ☐ No ☐ Yes *Name & Phone Number:* _____

Referral Details

Current Mental Health Concern and/or Diagnosis:

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Reason for Referral:

Person Referring: _____

Relationship to Participant: _____

Phone Number: _____

Email: _____

Referrer's Signature: _____ Date: _____

Additional Information

NDIS Plan in Place? ☐ No ☐ Yes NDIS Coordinator of Supports *(name/contact):* _____

Accessed TeamHEALTH Supports Previously? ☐ No ☐ Yes *List Services and Dates:* _____

Consent

TeamHEALTH is collecting this information to set up and provide your support. We'll store it securely and only share it where it's needed to arrange or deliver that support. You can ask to see or correct your information, or withdraw your consent, at any time. This won't affect the support you receive.

☐ I consent to this referral

Your information is handled in line with the *Privacy Act 1988 (Commonwealth),* the *Australian Privacy Principles*, and the NT *Information Act.*

Signature of Participant	Signature of Public Guardian (if applicable)	Date

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Risk Assessment (Referrer to complete)		
TeamHEALTH requires a brief participant risk assessment to ensure that we understand how to keep our staff, participants and community safe. If you are completing a self-referral and need assistance filling out a risk assessment, please call us on the phone number below.		
Participant risk factors *If selecting yes to any of the below, please expand on or attach relevant information/documentation.*	**Yes**	**No**
History of suicide attempt/s or current suicide ideation (e.g. chronic, recent)	☐	☐
Please provide further details:		
History of self-harm (e.g. chronic, recent)	☐	☐
Please provide further details:		
Recent traumatic life event (e.g. assault, bereavement, legal concerns, family violence, homelessness etc.)	☐	☐
Please provide further details:		
Historical or current drugs or alcohol use	☐	☐
If yes, please provide details of substances and any history of rehab or AOD counselling:		
Forensic history (including DVO, custodial orders, recent incarceration, upcoming legal matters, parole or bail conditions)	☐	☐
Please provide further details:		
Recent incident involving aggression/violence/weapon use or possession	☐	☐

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Risk Assessment (Referrer to complete)		
Please provide further details:		
Expressing intent to harm others/ Preoccupation/hallucinations with violent or paranoid themes/ideas	☐	☐
Please provide further details:		
Inappropriate sexual behaviour	☐	☐
Please list serious events or presenting behaviours:		
Reduced ability to self-control / difficulties with emotional regulation etc.	☐	☐
Please provide further details:		
Known prejudices – ethnic, religions, (including prejudices that emerge as part of psychosis)	☐	☐
Please provide further details:		
Vulnerabilities (financial abuse, trauma history, relational/sexual)	☐	☐
Please provide further details:		

Protective factors *(e.g. friends, family, professional relationships, culture, faith, hobbies, study, employment etc.)*

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Recommendations to support the safety and comfort of the person in our service *(e.g. safety plans, coping strategies, skills or strengths)*

Supporting Information Attached

☐ Risk assessment ☐ Supervision Order ☐ Community Management Order ☐ Other

Completing this Form

- Please call TeamHEALTH on 1300 780 081 if you need any assistance completing this form.
- Send the completed form to: teamhealth@teamhealth.asn.au.
- TeamHEALTH will contact the participant or Public Guardian within three working days of receiving this form.

Thank you for your referral

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