TOP END ASSOCIATION FOR MENTAL HEALTH INC

TEAMhealth Referral Form

TEAMhealth provides recovery focused psychosocial rehabilitation and early intervention programs for people and their families affected by mental illness. For further program specific information please refer to the TEAMhealth's website – teamhealth@teamhealth.asn.au - Self Referrals are accepted.

To enquire about a referral to each program please speak to the program Team Leader or Manager by phoning 1300 780 081.

Service/s Requested			
	Program	**Services Provided**	**Contact Details**
☐	Day to Day Living Program (D2DL)	Drop in and Day Program based in Rapid Creek. Provides support to access the Program from Palmerston weekly.	Ph: 08 8948 4055 Fax: 08 8948 5599
☐	Personal Helpers and Mentors (PHaMs)	Outreach support in the Top End, Rural and Remote areas for people who may, or may not, be engaged with clinical services and/or who are not currently engaged in any other service.	Ph: 08 8943 9600 Fax: 08 8943 9601
☐	Recovery Assistance Program (RAP)	Outreach support in Darwin, Palmerston and Katherine for people 18-64 yrs.	Ph: 08 8943 9600 Fax: 08 8943 9601
☐	Residential Services – Manse	24 hr supported long term accommodation in Darwin (18-64yrs) **NB: Referrals accepted only from Top End Mental Health Services (TEMHS)**	Ph: 08 8981 8417 Fax: 08 8981 6037
☐	Residential Services - Papaya	24/7 intensive residential step-up and step-down program for up to 4 weeks for people 16-64yrs. **NB: Referrals accepted only from Top End Mental Health Services (TEMHS)**	Ph: 08 8948 0501 Fax: 08 8948 4610

Applicant Details		
Name: Preferred Name:		DOB. Age: Gender: ☐ Male ☐ Female ☐ Other
Current address:		Contact Number:
Marital Status: ☐ Single ☐ Married ☐ De-facto ☐ Separated ☐ Widowed ☐ Divorced		Aboriginal: ☐ Yes ☐ No Torres Strait Origin: ☐ Yes ☐ No CALD: ☐ Yes ☐ No Non Indigenous ☐
Country of Birth:	Main Language spoken at home: ☐ English ☐ Other *(list):*_____	Interpreter Required: ☐ Yes ☐ No
Religion (optional):	Current Case Manager ☐ Yes ☐ No	HRN:

Case Management	
Case Manager:	Contact Details:
Current Diagnosed Mental Illness:	Secondary:

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 staff only)

Is the person currently in receipt of any other services?	**Does the person have any dependent children in their care?**	**Full Name & DOB**
☐ No ☐ Yes *(If yes what services?)* ☐ GP ☐ Psychologist ☐ NT FaCS ☐ TEMHS ☐ Somerville ☐ Anglicare ☐ Centacare ☐ Danila Dilba ☐ Other please specify: **Name:** **Phone:** **Email:**	☐ No ☐ Yes *(If yes name and age?)* →	**1.** ..... / / **2.** ..... / / **3.** ..... / / **4.** ..... / /

GP Details:
Name: _____ Phone: _____

Address: _____

Reason for Referral: _____
_____
_____
_____
_____

Carer Details			
Carer name:		**DOB:**	**Primary Language Spoken:**
Carer Address:		**Mobile:**	**Interpreter required:** ☐ Yes ☐ No
Relationship to Applicant:			

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).*

Mental health status: ☐ Current diagnosis ☐ Info on most recent episode or hospitalisation ☐ HE2ADS3 – *(youth psychosocial screening tool)* ☐ GP Mental Health Plan ☐ Previous psychiatric history/presentations ***For TEMHS & CAMHS Teams only:*** ☐ Current Care Plan (ICP) ☐ On Call assessment ☐ Relapse Prevention Plan ☐ Mental State Examination *(including level of insight)* ☐ Risk assessment (RATT) ☐ Current HoNOS *(Health of the Nation Outcome Survey)* ☐ Hospital Discharge Summary ☐ Nursing discharge plan and/or follow up letter.	Additional documentation attached ☐
Drug and/or alcohol: ☐ History, current use ☐ Impact current use has on lifestyle & treatment interventions ☐ Has a referral has been made to an AOD service ☐ Recent AOD assessment ☐ Insight re. Impact of use.	Additional documentation attached ☐
Medication management and support: ☐ Medication Management Plan **NB:** *All participants 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. Webster packs are required for all participants who stay in residential facilities.*	Additional documentation attached ☐

☐ Prescribed medication used including PRN use ☐ Support and management issues ☐ Compliance ☐ Side effects ☐ Route of administration ☐ Dose administration aids used ☐ Effectiveness ☐ Medication Management plan	
Physical illness: ☐ Epilepsy ☐ Asthma ☐ Heart Disease ☐ Acquired Brain Injury ☐ Infectious diseases such as hepatitis ☐ Allergies ☐ Nutrition or vitamin deficiencies ☐ Mobility issues ☐ Diabetes ☐ 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 ☐ Supervision Order	Additional documentation Attached ☐
Risk issues ☐ History of aggressive behaviour ☐ Previous risk to self and/or others, including staff ☐ History of verbal/physical aggressive behaviour ☐ Current Behavioural Management Plan	Additional documentation attached ☐
Supports ☐ Family/friends support available – e.g. parents, siblings, spouse, other close relatives, friends, ☐ involvement in community ☐ Education level ☐ Literacy and numeracy support ☐ Interpreter services	Additional documentation attached ☐
Any other special needs:	

Consent

Referring Agency to Complete:

☐ 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: _____

Signature of Public Guardian: _____

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

Referred Person to Complete:

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

☐ Top End Mental Health Services (TEMHS) ☐ My GP
☐ Private Psychiatrist ☐ Psychologist
☐ Northern Territory Police ☐ Corrections
☐ Other *(please specify)* _____

Signature of person being referred: _____ Date: _____

Guardian name and signature: _____ Date: _____

To assist with Assessment and Placement Options, please complete the Risk Assessment Matrix below.

Risk Assessment Matrix						
	No Problem	**Past but not Significant**	**Present but only Occasional**	***Present and Persistent***	***Present but only Occasional***	***Present and Persistent***
	Nil	Minor	Minor	Minor	Serious	Serious
Aggression						
Anti-Social Behaviour						
Drug Seeking Behaviour						
Drug &/or alcohol use						
Physical Illness						
Suicide Risk						
Self-harm						
Relationship Problems						
Vulnerable to Exploitation						
Daily Living Difficulties						
Domestic Violence						
Harassment from Others						
Gambling						

Risk Assessment completed by: ☐ The Applicant ☐ Agency Making Referral ☐ Third Party Information

Signature of Applicant: _____ Date: _____