TEAMhealth
TOP END ASSOCIATION FOR MENTAL HEALTH INC

Residential Services Referral Form

☐ **Papaya** Sub Acute Residential Program ☐ **Manse** Longer Term Residential Program	24/7 intensive residential step-up and step-down program for up to 8 weeks for people 18-64 yrs. **Phone:** 08 8948 0501 **Fax:** 08 8948 4610 24/7 intensive longer term residential program for up to 2 years for individuals unable to live independently for people 18-64 yrs. **Phone:** 08 8981 8417 **Fax:** 08 8981 6037

Consent

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) ☐ GP ☐ Psychiatrist ☐ Psychologist ☐ Corrections
☐ Other *(please specify)* _____

Signature of person being referred: _____ Date: _____

Guardian / Witness signature: _____ Date: _____

TEMHS worker signature: _____ Date: _____

Applicant Details

Name: Preferred Name:	D.O.B. Age: Gender: ☐ Male ☐ Female ☐ Other	
Current address:	Contact Number:	
Marital Status: ☐ Single ☐ Married ☐ De-facto ☐ Separated ☐ Widowed ☐ Divoced	Aboriginal: ☐ Yes ☐ No Torres Strait Origin: ☐ Yes ☐ No CALD: ☐ Yes ☐ No	
Country of Birth:	Main Language spoken at home: ☐ English ☐ Other *(list):*_____	Interpreter Required: ☐ Yes ☐ No
Accompanied by a boarder? ☐ No ☐ Yes - Details:	Religion *(Optional)*:	HRN:
Housing Type: *(Territory Housing, private, temporary)*	Current Diagnosed Mental Illness: Secondary:	

Case Management

Case Manager:	Contact Details:

Is there a current Community Management Order? ☐ No ☐ Yes *(Please attach a copy of Community Management Order)*
Community Management Order review date:

Do you have any legal guardian or Public Trust arrangements? ☐ No ☐ Yes *(please provide copies of any legal documents)*
Guardian / Public Trust name: _____
Contact details:
_____

Referral

Reason for referral / last inpatient mental health admission:

Family and living situation:

Next of Kin name:	Relationship:
Address:	Contact Number:

Living arrangement:
☐ Lives alone ☐ Lives with partner or spouse ☐ Lives with partner & children ☐ Lives with child/children
☐ Lives with Grandchild(ren) ☐ Lives with parents ☐ lives with significant other ☐ Other

☐ Lives in own home ☐ Lives in rental property ☐ Lives in hostel/boarding house
☐ Caravan ☐ Homeless ☐ Long grassing
☐ Emergency Accommodation ☐ Other *(e.g. hospital, friends)*
_____
_____
_____

Do you care for children or others? ☐ No ☐ Yes - Details:

Do you have children who are not in your care? ☐ No ☐ Yes - Details:

Medications

Do you take regular medications? ☐ No ☐ Yes
Do you have any concerns around medication? ☐ No ☐ Yes
Details:

Physical Health

Do you have any existing physical health conditions? ☐ No ☐ Yes
Details: *(include any medications)*

Do you have any allergies (food or medicines) ☐ No ☐ Yes
Details: *(include reaction signs and symptoms)*

Do you experience any impairment?
Vision ☐ No ☐ Yes Speech ☐ No ☐ Yes
Hearing ☐ No ☐ Yes Other ☐ No ☐ Yes
If yes to any of the above, please provide details:

Do you smoke tobacco? ☐ No ☐ Yes How many cigarettes per day_____
Do you use Alcohol and/or Other Drugs ☐ No ☐ Yes (*please provide details below)*

Drug type	Amounts	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Risk

Do you have an offending history? ☐ No ☐ Yes
Details:

Are you currently restricted in your ability to fully participate in the community *(i.e. detained in some way, on home detention or home movement restrictions)* that could impede full participation in activities? ☐ No ☐ Yes
Details:

Please provide details of self-harm or harm to others:

Exit Strategies

What is your exit plan for when you leave TEAMhealth residential services?
Details:

What is your emergency exit plan? *(unplanned exit)*
Details:

Cyclone exit plan:
☐ Return to your usual place of residence ☐ Emergency shelter ☐ Cowdy Ward ☐ Other *(address)*
Details:

Have you previously accessed TEAMhealth services? ☐ No ☐ Yes
Please provide details: *(service and dates)*

Referrer Details:		
Name:	Contact details:	Organisation:

Detail any concerns identified in your work with this participant:
(Include: Aggression / Violence current and prior)

Additional Information:

Attachment Checklist:	
Risk assessment	☐
Recovery plan / ICP	☐
Current medication chart	☐
CMO details	☐
Guardianship order	☐