

Wellbeing and Recovery – Remote Referral Form



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.

Wellbeing and Recovery – Remote is a free service for people living with a mental health condition or dealing with ongoing challenges that affect daily life, relationships, confidence, connection or wellbeing. Grounded in Social and Emotional Wellbeing (SEWB), support is shaped around what matters to each person, helping them build on their strengths, stay connected to community, and take practical steps towards the life they want.

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? _____ 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 a 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/How can TeamHEALTH support the referee?

☐ 1:1 Engagement ☐ Group Engagement ☐ Both 1:1 & Group

NDIS Plan:

☐ No ☐ Yes ☐ In process ☐ Assessment requested

Person Referring:

Relationship to Participant:

Phone Number:

Email:

Referrer's Signature:

Date:

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

In the absence of written consent, verbal consent was gained ☐ No ☐ Yes

Risk Assessment (Referrer to complete)

TeamHEALTH requires a brief 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 number below.

Participant risk factors

If selecting "yes" to any of the below, please expand on or attach relevant information/documentation.

History of suicide attempt/s or current suicide ideation (e.g. chronic, recent)

Yes

No

☐

☐

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	☐	☐
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:		

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Known prejudices – ethnic, religions, (including prejudices that emerge as part of psychosis)	☐	☐
Please provide further details:		
Vulnerabilities (e.g. 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)

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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!