Rural and Remote Mental health Service.
Barossa, Hills, Fleurieu Local Health Network
Mental Health Directorate

Application for Resource Referrals

- *Saltbush (Whyalla) Community Rehabilitation Service*
- *Community Rehabilitation Centres (Elpida House, Wondakka, Trevor Parry)*
- *Glenside Inpatient Rehabilitation Services*

Updated August 2022

Government of South Australia
SA Health

Consumer Information

Consumer name:			
Date of birth:			
CBIS / CCCME No:			
Primary Diagnosis: **Secondary Diagnosis (if app):**			
Safety concerns (circle):	AOD DV Home Environment (hoarding, animals, smoking etc) Forensics		
Income (circle):	DSP Newstart Sickness Benefits Family Allowance Salary Youth Allowance Aged Other: _____		
Education:			
Address (primary address, accommodation type, public/private rental, home owner, NFA):			
Household composition (circle):	Couple Couple with dependents Group (related) Group (unrelated) Single Single with dependents		
Current formal support services	Provider name/contact number: Service Received:		
Phone / mobile:			
Country of birth:			
Language/dialect:			
Identity (circle):	ATSI TSI CALD Australian Other:_____		
Orders (circle)	Administration Guardianship CTO Court Legal Other: _____		
Nominated Carer / Family member / NOK:		**Phone**:	
Children (names and ages):			
Children in care of consumer? Yes/No – if no, who is their carer?			

Pets? Assistance required – how?	

Referral Source

Date of referral:		**Team**:	
Worker's name:			
Position:			
Email:			
Phone number:			
Care Coordinator and CMHT (if different than the referrer; **please indicate if not allocated**)			

Endorsed by Team Manager

Name:	
Signature:	

Is the Community Mental Health Team Care Coordinator aware of the referral? YES / NO

Service Requested

Please tick all that apply:

☐ Saltbush (Whyalla) Community Rehabilitation Service

☐ Community Rehabilitation Centre (CRC)

☐ Elpida House ☐ Trevor Parry Centre ☐ Wondakka

☐ Glenside Inpatient Rehabilitation Services

☐ Other: _____

Attachments

Use the checklist below to ensure all documents are provided before sending the application for review.

☐ Authority for Release of Information

☐ My (Consumer) Perspective

☐ CBIS/ CCC CL11 Client Summary (includes current Mental Health Care Plan and NOCC scores)

☐ Current Risk Assessment (less than one week old)

☐ Discharge plan (if acute service)

☐ Occupational Therapy Assessment (mandatory)

Consumer Rehabilitation Information

Background Information.

- *Name, Age, mental health diagnosis (including any co-morbid diagnosis)*
- *Currently address.*
- *Brief psychiatric history, (including events leading to this rehabilitation referral)*
- *Financial situation/ income (DSP vs Job seeker)*
- *Forensic matters*
- *Legal matters*
- *Risk*

Please describe the reason for the service requested and how it will complement the person's rehabilitation / support plan. What is the person's current situation? How will the service enhance / support / build on the person's strengths / skills? How do the NOCC scores support this referral? What is the objective of the support required? How long might the service be required?

Please comment on the consumer's current suitability for rehab by considering;

- *Motivation; readiness for change (consumer's perspective on rehab and what they would like to change)*
- *Ability to learn new skills, inc knowledge (cognitive functioning/ ABI, ID)*
- *Ability to 'get along with others' in a communal setting. (Communication)*
- *Willingness to engage in the Program, inclusive of groups, 1:1 and treatment (medication)*

Please comment on the consumer's current level of functioning by considering;

- *Self, home, community (Phases of support) (inclusive of medication compliance)*
- *Level of independence*
- *Level of support (low, moderate, high) …family, friends, NGO, primary care, NDIS*
- *Brief summary of weekly/ fortnightly routine*

- *Self-perception of functioning, vs objective Ax*
- *HONOS scores and functioning relatability*

Please comment on the consumer's current pattern of illness and associated impact on functioning by considering;

- *Stressors and triggers*
- *Impact of risk (self and others) on functioning*
- *Current environment, social, physical demands*
- *Strengths and ability to self- appraise*
- *Productivity (employment, study), self-care, leisure occupations*
- *Current collateral information*
- *Recovery potential*

Please **highlight any relevant background / history** including personal growth / skill development / key interventions and outcomes that have been tried. Include prevention strategies.

Please comment on the consumer's <u>previous experience and functioning</u> by considering;

- *Prior roles*
- *Highest level of functioning (working, living independently?)*
- *Has the client lived their life as they wanted to live (before)*
- *Previous skills, knowledge to do the things they wanted/ needed to do*
- *What is their life like on a good day (previously)*
- *Previous education level, interests at school*
- *Previous episodes/ periods of wellness (how long, supports? Independence achieved)*
- *History of triggers for becoming unwell (client and others noticed)*
- *Client's experience of helpful interventions, resources, supports*
- *Developmental history (if relevant, age of onset)*

- *Any past relevant Ax (OT, neuro psych)*
- *Best year/s of their life (what did it look like occupationally)*
- *Previous interests (barriers to participating)*
- *Previous medications and impact on functioning*

Specify the respective community team's ongoing involvement / role in the person's rehabilitation plan and how they will support the requested service. Include what the plan is for ongoing psychiatric reviews, the proposed next step, e.g., post CRC / IRS, housing applications in place, SEP referral, HASP, SSH, etc.

Please comment on the future planning and support for the consumer' by considering;

- *What is the person aiming for (accommodation and support post CRS)*
- *Goals and aspirations*
- *Identified future supports (family, friends), who is going to be involved*
- *Availability of resources and opportunities (i.e., job seeking)*
- *Planning for discharge, re-integration early on*
- *Discharge destination if exiting the service prematurely*
- *Crisis, intervention planning*

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Application for Resources

My (Consumer) Perspective

This form comprises a guided interview or discussion with the consumer. It can be printed separately and taken to complete with the consumer, or left with them to complete. It must be attached to the application for resources.

Consumer name:	
Date of birth:	
How would you currently describe your mental health and wellbeing?	
Do you have any other health issues? (eg. physical / learning / illness / disability)	
Who are the people and/or organisations that are currently involved in your care? (who and how they help)	
What are your hopes and plans for the future? … (please describe)	

Things I would like to improve or get help with are: *Tick as many boxes as you think you need.*	☐ Getting organised, e.g., having a daily plan / routine ☐ Feeling clean and looking good ☐ Exercising and feeling healthy ☐ Quitting or reducing smoking / drinking / drug taking ☐ Looking after my home and garden ☐ Meal planning and shopping ☐ Cooking and eating good food ☐ Managing my money ☐ Arranging financial supports (pension or allowances) ☐ Getting to places – using transport ☐ Having a place to live ☐ Being with or seeing my family ☐ Parenting ☐ Making friends, meeting people ☐ Having more recreation, hobbies and sporting options ☐ Getting more involved in the community ☐ Finding work or learning something new ☐ Meeting my commitments to the criminal justice system ☐ Keeping appointments with people who can help me (doctors, legal representatives, other ☐ Other things that would help me are: _____ _____
I would need support: For how long?	☐ Daily ☐ Couple of times a week ☐ Weekly ☐ Fortnightly ☐ Weeks ☐ Months ☐ Years
I understand that if I went to a mental health rehabilitation service/ centre I will commit to working on my hopes and plans by setting goals with the Team.	☐ Yes ☐ No ☐ Unsure
I would like the following people involved in helping me with my hopes and plans:	☐ Partner ☐ Family ☐ Carer ☐ Friend ☐ Other: _____
I am happy for a Team member to come to my house every day.	☐ Yes ☐ No ☐ Unsure
When I become unwell I notice these things:	
I would like the following to happen when I get unwell:	

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Consumer signature: _____Date: _____

Application for Resources

Authority for Release/Exchange Information

I (full name) ……..……..……..……..……..……..……..……..……..……...

of (address) ……..……..……..……..……..……..……..……..……..……...

date of birth ……..……..……..……..……..……..……..……..……..……..

do hereby authorise the release and exchange of information between the following parties:

> GP

> SA Health

> NGO provider (IPRSS, IHBSS)

> NDIS

> Other: ……..……..……..……..……..……..……..……..……..……...

This information is required for the purpose of:

> Individual service planning.

> Service evaluation.

Full name: ……..……..……..……..……..……..……..……..……..……...

Signature: ……..……..……..……..……..……..……..……..……..……..

Date: ……..……..……..……..……..……..……..……..……..……...

This authority can be revoked at any time and is valid for 12 months from the date signed.

Forward completed referral and all relevant documents to Audrey.Mccall@sa.gov.au