

Wellways to Recovery referral form

PARTICIPANT DETAILS	
Family name:	Given names:
Date of birth:	Address:
Contact numbers:	Do you identify as Aboriginal or Torres Strait Islander? <input type="checkbox"/> Yes <input type="checkbox"/> No What gender do you identify as? _____ URN: _____

REFERRER DETAILS	
Referral date:	Referrer name:
Contact number:	Organisation:
Address:	Email:
	REFERRER SIGNATURE:

DIAGNOSIS:**CLINICAL SIGNOFF:**

Email referral: tasmania@wellways.org ☐ North-West 6419 7010 40 Mount Street, Burnie 7320
☐ North 6333 3111 6-18 George Street, Launceston 7250
☐ South 6169 0600 136 Davey Street, Hobart 7000

Has the person consented to this referral? ☐ Yes ☐ No

Has an information session occurred: ☐ Yes ☐ No Date: ____ / ____ / ____

REASON FOR REFERRAL:

- | | |
|--|---|
| <input type="checkbox"/> Managing mental health | <input type="checkbox"/> Responsibilities |
| <input type="checkbox"/> Relationships | <input type="checkbox"/> Social networks |
| <input type="checkbox"/> Physical health and self care | <input type="checkbox"/> Identity and self esteem |
| <input type="checkbox"/> Addictive behaviour | <input type="checkbox"/> Work |
| <input type="checkbox"/> Living skills | <input type="checkbox"/> Trust and hope |

PLEASE EXPLAIN THE REASON/S FOR REFERRAL INDICATED ABOVE:

HOW DOES DIAGNOSIS AFFECT PARTICIPANT (examples: relapse frequency, triggers, early warning signs etc):

Mental Health Order: ☐ Yes ☐ NoAdministration/Guardianship Order: ☐ Yes ☐ No

CURRENT LIVING ARRANGEMENTS:

PRESCRIBED MEDICATION:

Other comments:

OTHER HEALTH ISSUES (E.g. diabetes, cardiac conditions, allergies, alerts etc):

RISKS / SAFETY ISSUES: *Please provide notes regarding all risks rated moderate or high.*

	NONE	LOW	MOD	HIGH	DETAILS/OTHER COMMENTS
Suicidality (thoughts, plan, intent, history)					
Risk of harm to self					
Risk of harm to others					
Risk of harm from others					
Avoiding contact					
Barriers related to culture					
Inappropriate sexual behaviours					
Disability issues					
Cognitive impairment					
Impulsive behaviours					
Forensic history					
Other vulnerabilities (ie financial, neglect etc)					

COMORBIDITY ISSUES OR MISUSE (e.g. disability, alcohol, drug, gambling, hoarding):Current / recent: ☐ Yes ☐ NoType, frequency, and amount of use:

Does the client have relevant services involved: ☐ Yes ☐ NoPlease provide details:

FAMILY, SOCIAL SUPPORTS, COMMUNITY AGENCIES, OTHER AND/OR PETS INVOLVED:

Does the person have a Mental Health Plan? ☐ Yes ☐ No If yes please attachDoes the person have a Discharge Plan? ☐ Yes ☐ No If yes please attachOther/additional comments:

Is the person currently with DHHS Mental Health Services: ☐ Yes ☐ No