HASI Eastern Sydney
CLS South Eastern Sydney

*Mental Health Recovery Services*

t 1800 985 347
t 02 9508 3600
w missionaustralia.com.au

**MENTAL HEALTH RECOVERY SERVICES**

**HASI Eastern Sydney, CLS South Eastern Sydney Referral Form**

*A partnership between the NSW Ministry of Health and Mission Australia*

**Eligibility criteria:**

- ☐ Reside in the SESLHD and St Vincent's Hospital catchment
- ☐ Have a primary mental health diagnosis
- ☐ Aged 16 years and up
- ☐ Have a willingness to engage with the program *(participation is voluntary)*
- ☐ Have ongoing clinical support in the community

  *(ie SESLHD Mental Health clinician, GP, Psychiatrist, Psychologist)*
- ☐ Not have similar existing services in place

**Instructions:**

**Form 1: Applicant Information** (can be completed by applicant or support person)

**Form 2: Health and Legal Information** (must completed by allied health or medical practitioner)

Attach the following documents to your application:

- □ Current clinical risk assessment
- □ Most recent psychiatric or clinical review (if applicable)
- □ Discharge summaries and/or relevant medical reports (if applicable)

Send referral to:

*HASI&EACLSEasternSydneyReferrals@missionaustralia.com.au*

(02)9508 3600

To ensure your application is reviewed as quickly as possible, please return this form fully completed along with the above documents and signed consent form. Incomplete forms will be sent back to referrer.

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**FORM 1: APPLICANT INFORMATION**

*(This form can be completed by the applicant or support person)*

## APPLICANT DETAILS

| | |
|---|---|
| First name: | Last name: |
| Preferred name: | Date of birth: |
| Address: | |
| Relationship status: | Contact number: |
| Email: | |
| Assigned sex at birth:<br>☐ Male ☐ Other<br>☐ Female …….. | Identified Gender:<br>☐ Male ☐ Other<br>☐ Female …… |

## NATIONALITY & CULTURAL IDENTITY

| | |
|---|---|
| Country of birth: | |
| Australian citizenship/residency status:<br>☐ Citizen<br>☐ Temporary resident<br>☐ Permanent resident | Does the applicant identify as:<br>☐ Aboriginal and/or Torres Strait Islander<br>☐ Culturally & Linguistically Diverse<br>☐ Neither |
| Main language(s) spoken: | Is an interpreter required? |

## ACCOMODATION

Type of accommodation/living situation:

☐ Own home/private rental ☐ Homeless

☐ Supported accommodation ☐ Social housing

☐ Temporary accommodation (ie refuge, boarding house, crisis accommodation)

☐ Community housing (details of provider):

……..

If Homeless or living in Temporary accommodation,

Has a Housing Pathways application been lodged? ☐ Yes ☐ No

T-file number: Date of application:

Status of application:

Who does the applicant live with?

- ☐ Lives alone
- ☐ Family
- ☐ Other (specify): …….
- ☐ Friends
- ☐ House sharing tenants

If living with other people, how many people does the applicant live with?

Does the applicant live with any children? ☐ Yes ☐ No

If so, how many and what are the ages of the children?

## EMPLOYMENT & INCOME

Is that the applicant:

- ☐ Studying
- ☐ Retired
- ☐ Unemployed (looking for work)
- ☐ Unemployed (not looking for work/unable to work)

  Main reason:
- ☐ Employed – full-time
- ☐ Employed – part-time
- ☐ Employed – casual

Source(s) of income:

- ☐ Centrelink payment (specify):

  ……

- ☐ Other (specify):

  ……

**REASON FOR APPLICATION**

What are some of the applicant's **goals**? *(Think about any change(s) that the applicant wishes to make)*

How can HASI/CLS support with the above goals?

Applicant's strengths:

Applicant's current challenges:

*End of Form 1.*

**FORM 2: Health and Legal Information**

(*This form must be completed by allied health or medical practitioner*)

| **Psychiatric History** | |
|---|---|
| First Name: | Last Name: |
| DOB: | MRN: |

| **Current History** | | |
|---|---|---|
| Primary Mental Health diagnosis | | |
| ☐ Schizophrenia<br>☐ Schizo-affective disorder<br>☐ Bipolar Disorder<br>☐ Substance Use Disorder<br>☐ Significant or complex trauma<br>☐ Other (specify)…… | | ☐ Depression<br>☐ Anxiety<br>☐ Obsessive Compulsive Disorder<br>☐ Eating disorder<br>☐ Personality disorder (specify)<br>…… |
| Secondary Mental Health diagnosis (if any) | | |
| Primary signs and Symptoms | | |
| Currently inpatient? | ☐Yes ☐No | |
| If **Yes**, please specify: | | |
| - Facility | | |
| - Length of admission | | |
| - Discharge plan (if any) | | |
| Please specify the current management plan (i.e. medication trial, psychology interventions,..) | | |
| Medication prompt/supervision required? | ☐Yes ☐No | |
| Any CTO in place? | ☐Yes ☐No | |

| **Past History** |
|---|
| Previous mental health diagnosis |

| Previous ED presentation/Psychiatric hospitalisation |
|---|
| - How many in the last 24 months? |
| - Briefly describe the main reason for each: |
| ○ Date<br><br>○ Date<br><br>○ Date<br><br>○ Date<br><br>○ Date |
| Previous outpatient treatment |
| |

## CLINICAL SUPPORTS

Please detail the applicant's **clinical supports** in the community.

| Support Type | Name | Contact (email/phone) | Frequency |
|---|---|---|---|
| GP | | | |
| LHD Mental health clinician/ case manager | | | |
| Psychiatrist | | | |
| Psychologist | | | |
| Other allied health support | | | |

## NDIS & COMMUNITY SUPPORTS

| | |
|---|---|
| Is the applicant currently receiving NDIS services? | □ Yes □ No |

If **yes**,
Please outline the type of support the applicant is receiving:

| Agency/ Service | Type of support |
|---|---|
| | |
| | |
| | |

If **No,**

| | |
|---|---|
| Would the applicant benefit from NDIS? | □ Yes □ No |
| Has an application been submitted? | □ Yes □ No |
| What is the progress of the application? | □ Yes □ No |

Please outline any **non-NDIA** funded community programs/disability services involved:

| Service provider | Type of support | Contact (phone & email) | Frequency |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| | |
|---|---|
| Does the applicant have: | |
| - A carer? | □Yes □No |
| - A person responsible, legal guardian or power of attorney? | □Yes □No |
| - A financial management order in place? | □Yes □No |

If **Yes** to any of the above, please provide name and contact details:

| Name | Contact |
|---|---|
| | |

## LEGAL & CORRECTIONAL MATTERS

Any significant legal and correctional history? ☐ Yes ☐ No

If **Yes**, please select appropriately giving details as stated below:

| ☐ Incarceration | ☐ Current ☐ Previous |
|---|---|
| - Correctional facility/Community Corrections Office: | Name |
| | Contact number |
| - Period of Incarceration | |
| - Date of release from prison | |
| - Briefly detail the circumstances | |
| - Any court date planned? | ☐ Yes ☐ No<br>If **Yes**, specify when : |

| ☐ Pending legal issues | |
|---|---|
| - Give details | |
| - Any court date planned? | ☐ Yes ☐ No<br>If **Yes**, specify when : |

| ☐ Community corrections | |
|---|---|
| - Give details | |
| - Any court date planned? | ☐ Yes ☐ No<br>If **Yes**, specify when : |

**Past** Legal and correctional history in the last 10 years.
Please detail if any:

| Type | Date | Details |
|---|---|---|
| | | |
| | | |
| | | |

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## REFERRER DETAILS

Organisation/Practice:

Name:

Designation:

Contact number:

Email:

**Declaration**

The referrer agrees that all information submitted in this referral is an accurate reflection of the applicant's support needs, is correct with no information withheld and is necessary for Mission Australia to fulfil its duty of care to consumers, staff and other partner agencies.

**Referrer name**:

**Referrer signature:** ..... **Date**:

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**The Privacy Act requires the applicant to sign this form giving their consent for the release of their information and details.**

**CONSENT**

I, _____ give consent for HASI/EACLS support providers to seek/share relevant information with the following people/services/ organisations concerning matters related to this application for it to be considered:

☐ Yes ☐ No Relevant LHD Health Services and other health providers

☐ Yes ☐ No Relevant Housing providers

☐ Yes ☐ No Family members/carers (if applicable)

☐ Yes ☐ No Other NGO providers/ NDIA founded services

☐ Yes ☐ No Other service providers outlined in this referral

☐ Yes ☐ No De-identified statistics for programme evaluation for the period of this intake process.

I also give my consent to Mission Australia to keep a record of my referral and to contact the referring person or agency to update any information and to see if I am still interested in HASI/EACLS support.

Signed: _____ Date: