

# Referral Form

WHAT WE DO



Pathways SouthWest is a community mental health service, providing non-clinical recovery support for adults (over 18 years old) with severe and persistent mental health disorders. Individuals will receive individual engagement with a Recovery Worker to assist you through the mental health system. We will advocate for you, help you achieve your recovery and wellbeing goals, address self-stigma issues and strengthen illness management skills. Social peer group and support programs are also available.

Date of referral:

PARTICIPANT DETAILS		
Family name:	Given names:	
Address:		
Post code:		
D.O.B. / /	Age:	Sex M <input type="checkbox"/> F <input type="checkbox"/> Other <input type="checkbox"/>
Mobile:	Telephone:	
Email:		
Country of birth:	Languages:	
Reason for referral:		
Does client have an NDIS plan in place? YES <input type="checkbox"/> NO <input type="checkbox"/>	If YES - NDIS NUMBER: Plan Manager: Support Coordinator:	
Does the consumer have legal representation?	EPOA <input type="checkbox"/> Guardianship <input type="checkbox"/> SAT <input type="checkbox"/>	
Income source:	Aged <input type="checkbox"/> DSP <input type="checkbox"/> Job Seeker payment <input type="checkbox"/>	
EMERGENCY CONTACT (next of kin)		
Family name:	Given names:	Relationship:
Contact numbers:	Mobile:	Other:
Email:		

Deployed Dec 2023

Revalidate April 2026

Approved by CEO:

Signature:

Owner CEO

Author Coordinator Quality and Service Improvement

Version 2.1

Policy UNCONTROLLED ONCE PRINTED

GP DETAILS / CLINICAL SUPPORT NOTE: All participants need clinical support.			
Family name:		Given names:	
Organisation / Practice name:			
Contact numbers:	Office:	Fax:	Other:
Email:			

APPLICATION CRITERIA (Checklist – please tick)	
A severe and persistent mental illness (for example psychosis);	<input type="checkbox"/>
High risk of relapse and associated history of multiple hospitalisations;	<input type="checkbox"/>
Significant impairments in social, family, personal and occupational functioning that require intensive, ongoing support to enhance and maintain recovery;	<input type="checkbox"/>
Limited family and social support networks;	<input type="checkbox"/>
Comorbid substance use and/or physical illness	<input type="checkbox"/>
Reliance upon, and contact with, multiple agencies	<input type="checkbox"/>
Requirement for support from multiple sectors – such as housing and employment	<input type="checkbox"/>

HEALTH PROFESSIONAL TO COMPLETE :		
Primary diagnosis		
Secondary diagnosis/comorbidities		
Onset of illness	Year	Age
Brief history of mental illness: <i>Please describe.</i>		
General medical history: <i>Comorbidities.</i>		
Hospitalisation in the last 2 years? YES <input type="checkbox"/> NO <input type="checkbox"/> <i>if yes please describe.</i>		
History of self-harm/suicidality: <i>Note triggers including triggers and recent occurrences. Please include any current risk assessment.</i>		
Factors that may increase the risk of becoming unwell: <i>Please describe.</i>		

Allergies / adverse drug reactions: <i>Include non- medical allergies.</i> YES <input type="checkbox"/> NO <input type="checkbox"/>	
Living situation and supports?	Lives alone <input type="checkbox"/> Requires accommodation <input type="checkbox"/> Lives with others <input type="checkbox"/> In supported living <input type="checkbox"/>
Identified Community Supports: <i>Please list.</i>	
Home visiting/hazard alerts: <i>Please describe.</i>	
Legal issues: <i>Document any current legal orders e.g. Guardianship, Protective Office, document past, current, pending court cases, convictions for violent offences.</i>	

## RISK ASSESSMENT

***Please note: Referrals will not be actioned without an accompanying Risk Assessment.***

### GENERAL RISK FACTORS

Background factors	Y	N	U/K	Current factors	Y	N	U/K
Major psychiatric illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disorientation or	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diagnosed personality disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disinhibition/intrusive/impulsive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Serious medical condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Significant physical pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual disability/cognitive deficits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Significant behavioral disorder (<18 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Childhood abuse/maladjustment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### SUICIDAL IDEATION

Background factors	Y	N	U/K	Current factors	Y	N	U/K
Previous attempt(s) on own life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Expressing suicidal ideas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous serious attempt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has plan / intent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family history of suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Expresses high level of distress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Significant alcohol/drug use history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hopelessness/perceived loss of coping or control over life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Major physical disability/illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recent significant life events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Separated/widowed/divorced	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reduced ability to control self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of job / retired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Current misuse of drugs/alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Isolation/lack of supports/supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VIOLENCE / AGGRESSION								
Background factors	Y	N	U/K	Current factors	Y	N	U/K	
Previous incidents of violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Expressing intent to harm others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Previous use of weapons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Access to available means	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Male	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paranoid ideation about others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Under 35 years old	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Command hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Forensic /Criminal history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anger, frustration or agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Previous/violent ideation or acts of violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Preoccupation with violent ideas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Role instability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reduced ability to control self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

OVERVIEW / IMPRESSION / ASSESSMENT OF RISK					
Is this person's level of risk changeable?			YES <input type="checkbox"/>	NO <input type="checkbox"/>	Unsure <input type="checkbox"/>
Are there factors that contribute to uncertainty regarding the level of			YES <input type="checkbox"/>	NO <input type="checkbox"/>	Unsure <input type="checkbox"/>
(If YES) what?					
<b>GENERAL</b>		Low <input type="checkbox"/>	Medium <input type="checkbox"/>	High <input type="checkbox"/>	No Risk <input type="checkbox"/>
<b>SUICIDAL IDEATION</b>		Low <input type="checkbox"/>	Medium <input type="checkbox"/>	High <input type="checkbox"/>	No Risk <input type="checkbox"/>
<b>VIOLENCE</b>		Low <input type="checkbox"/>	Medium <input type="checkbox"/>	High <input type="checkbox"/>	No Risk <input type="checkbox"/>
<b>FAMILY / DOMESTIC VIOLENCE</b>		Low <input type="checkbox"/>	Medium <input type="checkbox"/>	High <input type="checkbox"/>	No Risk <input type="checkbox"/>
<b>OVERALL</b>		<b>Low <input type="checkbox"/></b>	<b>Medium <input type="checkbox"/></b>	<b>High <input type="checkbox"/></b>	<b>No Risk <input type="checkbox"/></b>
History of predatory behaviour		Recent/current violence			
Inappropriate sexual behaviour <small>(Past or present)</small>		Current misuse of drugs/alcohol			

**ADDITIONAL INFORMATION (INCLUDING PROTECTIVE FACTORS)**

REFERRER DETAILS (Who is filling out this form?)		
First Name :	Surname :	Organisation / Practice name:
GP: <input type="checkbox"/> Psychiatrist: <input type="checkbox"/> Mental Health Professional: <input type="checkbox"/> Other - details: <input type="checkbox"/>		
Contact numbers:	(M)	(Other)
Email address:		
Signed:		

**THIS REFERRAL PROVIDES CONSENT TO SHARE INFORMATION RELATED TO THE CONSUMER FOR A PERIOD OF 12 MONTHS.**

When completed email to [referrals@pathwayssouthwest.org.au](mailto:referrals@pathwayssouthwest.org.au)