Mental Health Step Up/Step Down Service – Albany

Referral form

The Mental Health Step Up/Step Down Service – Albany provides short-term residential mental health support for people who are either becoming unwell and at risk of being admitted to hospital or leaving hospital but in need of extra support to transition back into the community. Please fill in this form to make a referral to the service and email it to albany@neaminational.org.au

The service provides support for people who:

- Are aged 16 years and over (those aged 16-17 years may require additional consent)
- Are primarily experiencing a mental health challenge.
- Are able to engage cooperatively in a group setting and willing to participate in the programs offered.
- Are not currently experiencing homelessness.

Section 1 – Basic information

Full name: DOB:

Address: Email address:

Contact number:

Gender: ◯ Male ◯ Female ◯ Transgender ◯ Indeterminate-Intersex ◯ Not stated ◯ Other:

Indigenous status: ◯ None ◯ Aboriginal origin ◯ Torres Strait Islander origin ◯ Both Aboriginal and Torres Strait Islander origin ◯ Not stated/chose not to disclose

Section 2 – Referrer information

Referrer name: Designation:

Service: Contact:

Email: Referral date:

Referral urgency: ◯ Non-urgent ◯ Urgent

Section 3 – Consumer consent for referral

Consumer has consented for referral ◯ Yes ◯ No (if no, please obtain consent prior to submitting)

This referral form collects information to assist Neami National provide the services and support a consumer may need.
All information will be treated confidentially and will only be used for the purposes for which it is collected.

I consent to be referred to Neami National, and give Neami National permission to contact my referrer/clinical supports. Neami National will contact my referrer/clinical supports to obtain information relevant to providing care and services to me. If this is a self-referral, I consent for my referrer/clinical supports to be contacted and to obtain information relevant to providing care and services to me. I understand that I can withdraw from this referral or from the referred service at any time.

Consumer signature: _____ Date:

OR
Verbal consent obtained by referrer

Referrer signature: _____ Date:

Guardianship order? ◯ Yes ◯ No

Case Manager will continue normal treatment responsibilities including monitoring, review and re-assessment ◯ Yes ◯ No

Section 4 – Current supports

Carer/NOK details

Name: | Relationship to consumer:

Contact number:

Psychiatrist details

Name: | Practice:

Contact number:

GP details

Name: | Practice:

Contact number:

Other

Name: | Practice:

Contact number:

Section 5 – Consumer details

Reason for referral:

Psychiatric history:

Diagnosis:

Presenting problems (referrer's perceptions):

Consider: precipitants, history of current episode & treatment, signs & symptoms (hallucinations, abnormal ideation, preoccupations, suicidal ideation, aggression, anxiety states, mood disturbance, sleep, appetite, substance abuse, other disability), IDS/physical, consumer's perception of problem, demographics

Medication

Current medication:

Depot information:

Next due: Frequency:

Medication compliance:

Risk assessment

Risk assessment attached? ◯ Yes ◯ No

Alerts/safety issues:

Drug/alcohol issues:

Legal/forensic issues: CTO? ◯ Yes ◯ No

Current circumstances

Housing:

Dependants (children/elders):

Please email completed form to albany@neaminational.org.au

Contact us

Albany Step Up/Step Down
17 Diprose Crescent, Spencer Park WA 6330
08 6323 8900 | albany@neaminational.org.au

neami national
Improving Mental Health and Wellbeing

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Completed by Service Manager:

Assessment outcome: ◯ Accepted ◯ Not accepted

If not accepted, provide details:

Consumer advised by: Date:

Referrer advised by: Date: