

# Mental Health Step Up/Step Down Service – Joondalup (JMHS)

## Referral form

The Mental Health Step Up/Step Down Service – Joondalup 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 [jmhsreferrals@neaminational.org.au](mailto:jmhsreferrals@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 [jmhssreferrals@neaminational.org.au](mailto:jmhssreferrals@neaminational.org.au)

**Contact us**

**Mental Health Step Up/Step Down Service – Joondalup (JMHS)**

22 Upney Mews, Joondalup WA 6029

08 6200 9165 | [jmhssreferrals@neaminational.org.au](mailto:jmhssreferrals@neaminational.org.au)



**OFFICE USE ONLY**

Completed by Service Manager:

Assessment outcome:

Accepted

Not accepted

If not accepted, provide details:

Consumer advised by:

Date:

Referrer advised by:

Date: