

# Community-based Mental Health Support WA Referral form

To be eligible for Neami National services you must be between 18-65 years, have a mental health diagnosis, be linked with a mental health professional (GP, Psychologist, Psychiatrist or Community Mental Health Service) and not have an existing NDIS plan for mental health support.

## Consumer details

Full name	
Gender	Gender pronouns
Street address	No fixed address
Phone	Mobile
Email	DOB

## Indigenous status

Aboriginal but not  
Torres Strait Islander

Torres Strait Islander  
but not Aboriginal

Both Aboriginal and  
Torres Strait Islander

South Sea Islander

Neither Aboriginal nor  
Torres Strait Islander

Not stated/inadequately  
described

## Current clinical support

### Primary support

Service	Address
Phone	Email

### Secondary support

Service	Address
Phone	Email

## Referrer details

If this is a self-referral, please include details of mental health diagnoses in the 'Presentation' section below.

Referrer name \_\_\_\_\_

Agency \_\_\_\_\_

Role/relationship \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

Email \_\_\_\_\_

**Please attach any current treatment plans, risk assessments and discharge summaries.**

## Presentation

**Mental health diagnoses/date given** (if known)

**Current medication**

**Does the consumer have a current risk assessment?** (if yes, please attach)

Yes

No

**Verbal/physical aggression**

Yes

No

**Has the consumer been informed of referral?**

Yes

No

**Was the consumer admitted to hospital in the last 6 months?**

Yes

No

**Has the consumer had any emergency presentations due to a decline in their mental health over the last six months?**

Yes

No

**Is the consumer currently on bail or is there a Community Treatment Order in place?**

Yes

No

**Legal/forensic issues** (if yes, please outline below)

Yes

No

## Emergency contact

Full name \_\_\_\_\_

Relationship \_\_\_\_\_

Phone \_\_\_\_\_

## Planning

What do you want the focus to be for your Mental Health wellbeing?

What are your goals?

## Consent to share information

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**Referrer signature** (if not self-referral)

**Date**

This Neami National referral form collects information to assist Neami National staff to help consumers get access to the services they may need. By signing this form, 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 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. All information will be treated confidentially and will only be used for the purposes stated on the consent form (signed when the consumer first engages with services).

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**Consumer/guardian signature**

**Date**

Submit this form to your closest Neami service.  
If you're unsure about which service to submit to, contact us on 08 9527 5547.

**Submit to Mandurah**

ReferralsSouth@neaminational.org.au  
Phone 08 9535 9326

**Submit to Perth**

ReferralsNorth@neaminational.org.au  
Phone 08 6252 0420

**Submit to Rockingham**

ReferralsSouth@neaminational.org.au  
Phone 08 9527 5547

**Submit to Joondalup**

ReferralsNorth@neaminational.org.au  
Phone 08 9301 1227

Wait times for assessment and services vary. Please contact your local Neami service for an estimated wait time for your catchment area.