HASI Referral Form

IMPORTANT! Please ensure you have attached the applicant's clinical risk assessment and/or their clinical case review form when submitting. Return this Referral Form to Neami Wollongong at wollongong@neaminational.org.au

SECTION A - REFERRAL INFORMATION

Eligibility criteria

Applicant must meet all of the following eligibility criteria (please tick).

- ☐ Reside in Illawarra region of the Illawarra Shoalhaven Local Health District (ISLHD)
- ☐ Be 16yrs old or above
- ☐ Have an ongoing clinical support person who will collaborate with us and is in the relevant LHD (e.g. area case manager, GP, psychiatrist, psychologist, etc.).
- ☐ Have been diagnosed with a Mental Health condition
- ☐ Willingness and capacity to engage in HASI

*HASI does not require a formal diagnosis for the following:

- Aboriginal and Torres Strait Islander people who have experiences such as an issue with social and emotional wellbeing due to factors such as, unresolved grief and loss, trauma, abuse or domestic violence, substance misuse, removal from family or family breakdown, cultural dislocation, racism or discrimination and social disadvantage.
- A person 16-24 who has functional impairment due to psychological disturbance, which a mental health professional has identified.
- A refugee or asylum seek has psychological distress, mental ill health, and impaired functioning.

Source of referral

Date of referral		Organisation/hospital	
Name of referrer			
Role		Contact number	
Email			

Has the applicant ever been supported by a HASI/CLS provider in the past?	☐ Yes	☐ No	*If yes, what was the name the provider and the start/end dates.

SECTION B - APPLICANT INFORMATION

Contact details

First name		Last name	
DOB		Preferred/main contact number	
Address			
MRN		Alternative contact person	

Gender/sexuality

Gender	
Preferred Pronoun	
Sexuality	

Cultural Identity

Does applicant identify as:

☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐ Cultural & Linguistically Diverse

☐ None of the above

Country of birth		Main language spoken at home	
Refugee status			

Interpreter required? ☐ Yes ☐ No

SECTION C - HEALTH INFOMATION

A. Primary diagnosis – SELECT ONE ONLY

☐ Schizophrenia ☐ Anxiety Disorder ☐ PTSD ☐ Complex PTSD

☐ Bipolar Affective Disorder Type 1 ☐ Bipolar Affective Disorder Type 2 ☐ Eating Disorder ☐ Personality Disorder

☐ Depression ☐ Schizo-affective Disorder ☐ Borderline Personality Disorder ☐ Obsessive-Compulsive Disorder

☐ Other - please specify:

B. Secondary diagnosis

- [ ] Schizophrenia
- [ ] Anxiety Disorder
- [ ] PTSD
- [ ] Complex PTSD
- [ ] Bipolar Affective Disorder Type 1
- [ ] Bipolar Affective Disorder Type 2
- [ ] Eating Disorder
- [ ] Personality Disorder
- [ ] Depression
- [ ] Schizo-affective Disorder
- [ ] Borderline Personality Disorder
- [ ] Obsessive-Compulsive Disorder
- [ ] Other - please specify:

C. Other co-existing factors impacting on mental illness - tick all that apply

- [ ] Intellectual Disability
- [ ] Physical Disability
- [ ] Acquired Brain Injury
- [ ] Experiencing Family or Domestic violence
- [ ] AOD misuse - please specify:

D. Other medical conditions

- [ ] Arthritis and musculoskeletal
- [ ] Diabetes
- [ ] Kidney disease
- [ ] Asthma and other respiratory
- [ ] Hepatitis C, have you ever had it?
- [ ] Oral health conditions
- [ ] Cancer
- [ ] Is your HIV status positive?
- [ ] Cardiovascular including hypertension
- [ ] Other - please specify

SECTION D - ACCOMMODATION STATUS

- [ ] Public Housing
- [ ] In Hospital
- [ ] Insecure housing
- [ ] Community Housing
- [ ] Emergency temporary accommodation
- [ ] Private Dwelling
- [ ] Correctional facility
- [ ] Living with friends and family as long term arrangement
- [ ] Specialist homeless service
- [ ] Other - please specify
- [ ] Boarding/Rooming House
- [ ] Unknown/not stated

SECTION E - CLINICAL AND OTHER SUPPORTS

Does the applicant have a legal guardian?	☐ Yes	☐ No	If applicable, please specify name and contact details of legal guardian or support person:		

Support Details:

Does the applicant have a support person? ☐ Yes ☐ No

If Yes, Name		Relationship	

Does the support person live with the applicant? ☐ Yes ☐ No

Contact details	

Key clinicians involved

	Name	Contact details	Frequency of contact with applicant
Allied health worker			
Psychologist			
Psychiatrist			
G.P.			
Other (specify)			

Does the applicant currently receive clinical support from the Community Mental Health Team? ☐ Yes ☐ No

Name			
Mental Health Team			
Phone		Email	

Receiving the National Disability Insurance Scheme ☐ Yes ☐ No

If No, has an application for the NDIS been started ☐ Yes ☐ No

If yes, current status of NDIS application:	

SECTION F - HEALTH HISTORY

Summary of Mental Health/ psychiatric history:	
What does the applicant require support with? (consider applicants recovery based goals, daily living skills, developing relationships with clinical supports, access to education, navigate different support systems)	

Psychiatric Hospital Admissions

Impatient admissions in the last 24 months

Hospital	Date of admission	Date of discharge	Number of days

SECTION G - LEGAL STATUS

A. Community-based orders issued by courts

- ☐ No order
- ☐ Good behaviour bond
- ☐ Community service orders
- ☐ Intensive correction orders
- ☐ Home detention orders
- ☐ Parole orders
- ☐ Extended supervision orders
- ☐ Drug court orders
- ☐ Other combination - please specify:

B. Legal status

- ☐ No order
- ☐ Community Treatment Order (CTO)
- ☐ Forensic Order
- ☐ Guardianship and Financial Management (FM) Order
- ☐ Parole Order
- ☐ Other combination - please specify:

C. Forensic history

- ☐ Current
- ☐ Previous History
- ☐ Pending legal issues
- ☐ Probation
- ☐ Parole
- ☐ Community-based detention order
- ☐ Other - please specify:

Risk Assessment

A copy of your Risk Assessment needs to be attached to this form

- ☐ Aggression and violence
- ☐ Self-neglect
- ☐ Vulnerability (Exploitation/Reputation)
- ☐ Sexual Safety/ Domestic or Family Violence
- ☐ Suicide and self-harm
- ☐ Environmental risks
- ☐ AOD — If yes ☐ Harmful ☐ Unharmful
- ☐ Other - please specify:

Are there any risk factors that indicate preferred staff allocation? (E.g. need for two workers, intimidated by a specific gender, danger to a specific gender)	

SECTION H - CONSUMER CONSENT TO SHARE INFORMATION

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

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

- ☐ Relevant Area Health Services and other Health providers
- ☐ Family members/carers (if applicable)
- ☐ Other service providers outlined in this referral
- ☐ De-identified statistics for program evaluation for the period of this intake process.

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

Signed:		Date:	

OR

☐ Please tick if verbal consent was provided by the consumer.

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 HASI/CLS service provider to fulfill its duty of care to consumers, staff and other partner agencies.

Referrer Signature:		Date:	

SECTION I - CHECKLIST

- ☐ Clinical risk assessment is attached
- ☐ Latest clinical case review form is attached
- ☐ Copy of referral given to legal guardian

Please return this Referral Form to Neami National Wollongong at
wollongong@neaminational.org.au
You will receive a response from a member of our team within 5 working days.