wellways

Wellways to Recovery referral form

Tasmania
Explore the possibilities

In collaboration with Mental Health Services Tasmania

FILE IN CORRESPONDENCE

PARTICIPANT DETAILS

Family name: <type here>	Given names: <type here>
Date of birth: <dd/mm/yyyy>	Address: <type here>
Contact numbers: <type here>	Do you identify as Aboriginal or Torres Strait Islander? ◯ Yes ◯ No What gender do you identify as? <type here> URN: <type here>

REFERRER DETAILS

Referral date: <dd/mm/yyyy>	Referrer name: <type here>
Contact number: <type here>	Organisation: <type here>
Address: <type here>	Email: <type here>
	REFERRER SIGNATURE:

DIAGNOSIS: <type here>

CLINICAL SIGNOFF: <type here>

Email referral: **tasmania@wellways.org**

◯ North-West	6419 7010	40 Mount Street, Burnie 7320
◯ North	6333 3111	6-18 George Street, Launceston 7250
◯ South	6169 0600	136 Davey Street, Hobart 7000

Has the person consented to this referral? ◯ Yes ◯ No

Has an information session occurred: ◯ Yes ◯ No Date: <dd/mm/yyyy>

REASON FOR REFERRAL:

- ☐ Managing mental health
- ☐ Relationships
- ☐ Physical health and self care
- ☐ Addictive behaviour
- ☐ Living skills
- ☐ Responsibilities
- ☐ Social networks
- ☐ Identity and self esteem
- ☐ Work
- ☐ Trust and hope

PLEASE EXPLAIN THE REASON/S FOR REFERRAL INDICATED ABOVE:

<type here>

HOW DOES DIAGNOSIS AFFECT PARTICIPANT (examples: relapse frequency, triggers, early warning signs etc):

<type here>

Mental Health Order: ◯ Yes ◯ No Administration/Guardianship Order: ◯ Yes ◯ No

CURRENT LIVING ARRANGEMENTS:

<type here>

PRESCRIBED MEDICATION: <type here>

Other comments: <type here>

OTHER HEALTH ISSUES (E.g. diabetes, cardiac conditions, allergies, alerts etc):

<type here>

RISKS / SAFETY ISSUES: *Please provide notes regarding all risks rated moderate or high.*

	NONE	LOW	MOD	HIGH	DETAILS/OTHER COMMENTS
Suicidality (thoughts, plan, intent, history)	◯	◯	◯	◯	<type here>
Risk of harm to self	◯	◯	◯	◯	<type here>
Risk of harm to others	◯	◯	◯	◯	<type here>
Risk of harm from others	◯	◯	◯	◯	<type here>
Avoiding contact	◯	◯	◯	◯	<type here>
Barriers related to culture	◯	◯	◯	◯	<type here>
Inappropriate sexual behaviours	◯	◯	◯	◯	<type here>
Disability issues	◯	◯	◯	◯	<type here>
Cognitive impairment	◯	◯	◯	◯	<type here>
Impulsive behaviours	◯	◯	◯	◯	<type here>
Forensic history	◯	◯	◯	◯	<type here>
Other vulnerabilities (ie financial, neglect etc)	◯	◯	◯	◯	<type here>

COMORBIDITY ISSUES OR MISUSE (e.g. disability, alcohol, drug, gambling, hoarding):

Current / recent: ◯ Yes ◯ No

Type, frequency, and amount of use: <type here>

Does the client have relevant services involved: ◯ Yes ◯ No

Please provide details: <type here>

FAMILY, SOCIAL SUPPORTS, COMMUNITY AGENCIES, OTHER AND/OR PETS INVOLVED:

<type here>

Does the person have a Mental Health Plan? ◯ Yes ◯ No If yes please attach

Does the person have a Discharge Plan? ◯ Yes ◯ No If yes please attach

Other/additional comments: <type here>

Is the person currently with DHHS Mental Health Services: ◯ Yes ◯ No