Mental Health Association of Central Australia
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MHACA Referral/Intake Form

This document relates to the referral of persons to services and programs of the Mental Health Association of Central Australia (MHACA).

Details of Person Being Referred

First name: ______________________ **Last name:** ______________________

Skin/preferred/other name(s): ______________________ **Date of birth:** ___ ___ / ___ ___ / ___ ___ ___ ___

Gender: ______________ Prefer not to say ☐ **Pronouns:** he/him ☐ she/her ☐ they/them ☐ Other ________

Address: ____

Type of accommodation: Homeowner☐ Rental☐ Public Housing☐ Other______________________

Phone: ______________________ **Email:** ______________________

Preferred communication method: Phone ☐ Text ☐ Email ☐

Citizenship: ______________________ **Ethnicity:** ______________________

Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander ☐ Other ______________

Relationship Status: Single (never married) ☐ Partnered ☐ Married ☐ Divorced ☐ Other ______________

Accessibility

Preferred language(s): ______________________ **Interpreter required?** Yes ☐ No ☐

Name of interpreter: ______________________ **Agency:** ______________________

Preferred gender of worker: ______________ *Note: accommodating for this will depend on staff availability*

Specific access requirements (e.g., physical, cultural, sensory impairment): ______________________

____

Emergency Contact Details

First name: ______________________ **Last name:** ______________________

Relationship to referred person: ______________________ **Phone:** ______________________

Address: ____

Referral Information

Type of referral: Self-referral ☐ Case manager ☐ Service provider ☐ Family member ☐ Significant other ☐

Other ______________________ **Date of referral:** ___ ___ / ___ ___ / ___ ___ ___ ___

If not a self-referral, please provide your details below (where applicable):

Referrer name: ______________________ **Role title:** ______________________

Service Provider / Agency name: ____

Phone: ______________________ **Email:** ______________________

Other services/practitioners working with referred person (e.g., Central Australian Health Service – Mental Health):

Reason for referral:

Program for referral: Pathways to Recovery (individual support) ☐ Group Activities ☐ Housing and Homelessness Support ☐ National Disability Insurance Scheme (NDIS) Support Coordination ☐ Other

Mental and Physical Health History

Primary mental health condition(s):

Secondary mental health condition(s):

Co-existing physical health condition(s):

Current mental health state:

Recent hospitalisation(s): Yes ☐ No ☐ If yes, please provide detail and include date of admission(s):

Prescribed medication:

Allergies:

Covid-19 Vaccination Status: 2 doses + booster ☐ 2 doses ☐ 1 dose ☐ No doses (not vaccinated) ☐

Current NDIS Plan: Yes ☐ No ☐ If yes, does the referred person have a Support Coordinator? Yes ☐ No ☐

Support Coordinator contact details:

Risk Indicators (please provide details)

Risk of self-harm and/or suicide :

Risk of harm to others (e.g. violent/threatening behaviours):

Forensic History

Does the referred person have a criminal record? Yes ☐ No ☐ Unsure ☐ If yes, please describe type of offence(s):

Has the referred person engaged in inappropriate sexual behaviour? Yes ☐ No ☐ Unsure ☐ If yes, please describe:

Are there any current orders in place (e.g., Guardianship, Treatment, Domestic Violence)? Yes ☐ No ☐ Unsure ☐
If yes, please describe:

External Involvement in Care

Consent for family member/ carer/support worker/another person to be involved in care: Yes ☐ No ☐

If yes, and they are different to the emergency contact, please provide their contact details below:

First name: ______________________ **Last name:** ______________________

Relationship to referred person: ______________________ **Phone:** ______________________

Address: ______________________

Supporting Documents

Please indicate which relevant supporting materials are attached (if applicable):

☐ Risk Management Assessment/Plan ☐ Hospital Discharge Summary

☐ Individual Care Plan or similar (last 6 months) ☐ Allied Health reports (last 18 months)

☐ Health of the Nation Outcome Scales (HoNOS) ☐ Other: ______________________

Declaration

If the referral is being made by anyone other than the participant themselves, the participant must sign below to acknowledge that they are aware of and consent to the referral.

I, ______________________ , consent to this referral being made on my behalf. By signing this declaration, I agree that the personal information contained in this referral may be shared with MHACA if it is relevant to my care.

Signature of person or representative being referred: ______________________ **Date:** ___ ___ / ___ ___ / ___ ___ ___ ___

I, ______________________ , declare that all the information provided in this document is accurate to the best of my knowledge. I have made every reasonable effort to provide correct information myself (if making a self-referral) OR I have obtained correct information from the participant and/or other parties involved.

Signature of referrer: ______________________ **Date:** ___ ___ / ___ ___ / ___ ___ ___ ___

If unable to obtain a signature, verbal consent has been provided.

Date: ___ ___ / ___ ___ / ___ ___ ___ ___ **Time:** _______ **Location:** ______________________

Please contact MHACA's Intake Team with any enquiries
Mental Health Association of Central Australia (MHACA)
14 Lindsay Avenue, East Side NT 0870
Phone: (08) 8950 4600 Fax: (08) 8952 1574 Email: intake@mhaca.org.au

*****OFFICE USE ONLY*****

Date referral received: ___ ___ / ___ ___ / ___ ___ ___ ___ **Referred elsewhere?** Yes ☐ No ☐ If yes, where:

____

Intake appointment date: ___ ___ / ___ ___ / ___ ___ ___ ___ **Appointment attended?** Yes ☐ No ☐

Accepted into a program? Yes ☐ No ☐ If yes, which program: ____________________________________

Further action: ____

Approved by: ____________________________________ Coordinator ☐ Program Manager ☐