



MHACA



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 _____

Who does the person live with: Self Partner Children 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): _____

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:** _____

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 _____

Support People and Services

Personal support people (e.g., Family, Carers, Guardianship)

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Other services/practitioners working with the referred person (e.g., CAMHS, GP, DASA)

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

Support coordinator contact details: _____

Emergency contact

Name: _____ Relationship: _____ Contact: _____

Mental and Physical Health History

Primary mental health condition(s): _____

How long has the person been impacted by this condition(s): _____

Is the person on any medication for this condition(s): Yes No If yes, please list type(s):

Secondary mental health condition(s): _____

How long has the person been impacted by this condition(s): _____

Is the person on any medication for this condition(s): Yes No If yes, please list type(s):

Physical health condition(s): _____

How long has the person been impacted by this condition(s): _____

Is the person on any medication for this condition(s): Yes No If yes, please list type(s):

Is the person on any other medications, if yes please describe and list reasons: _____

Does the person take their medication as prescribed? Yes No If no, please provide details below

Current mental health state: _____

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

Does the person have any allergies? Yes No If yes, please describe:

Risk Indicators

History of self-harming behaviours? Yes No Unsure If yes, please provide details below

Main method/s and most recent occasion: _____

Currently at risk of self-harm? Yes No Unsure

History of suicide attempts? Yes No Unsure If yes, please provide details below

Main method/s used and most recent attempt: _____

Currently at risk of suicide? Yes No Unsure

History of harming others? Yes No Unsure If yes, please provide details below

Type of harm and to whom: _____

Was a weapon involved? Yes No Unsure If yes, please provide details below

History of having choked someone? Yes No Unsure

History of damage to a property? Yes No Unsure

History of using fire/petrol to harm others or property? Yes No Unsure

History of harm to animals? Yes No Unsure

History of inappropriate sexual behaviour? Yes No Unsure If yes, please describe below

Has the person received treatment to address their inappropriate sexual behaviours? Yes No

If yes, please provide details _____

History or current substance use? Yes No Unsure If yes, please provide details.

If yes, is the person receiving treatment or support?

Forensic History

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

Has the person ever been convicted for use of serious violence? Yes No Unsure

Has the person ever been convicted for sexual assault? Yes No Unsure

If yes to the above please provide details of dates and rehabilitation programs the person has been involved in:

Is the person current on bail/parole or a community order? Yes No Unsure If yes, please provide details

Does the person have a current Domestic Violence Order in place? Yes No Unsure If yes, please provide details

Type: Non-Contact DVO Non-Intoxication DVO **Expiry date:** _____

Protected person/s: _____

Are there any other current orders in place? (e.g., Guardianship, Treatment) Yes No Unsure

If yes, please describe:

Other information

Does the person currently have any other worries/stresses? (e.g., children, unemployment, legal, substance misuse)

Supporting Documents

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

- Criminal record
- Risk Management Assessment/Plan
- Individual Care Plan or similar (last 6 months)
- Health of the Nation Outcome Scales (HoNOS)
- Bail/Parole conditions
- Hospital Discharge Summary
- Allied Health reports (last 18 months)
- 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)

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