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______________

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
☐ Bail/Parole conditions
☐ 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

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