**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.

______________________________________________________________________________

**Is there a chronic disease management plan for the person?** Yes ☐ No ☐ If yes, 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 acommunity 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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