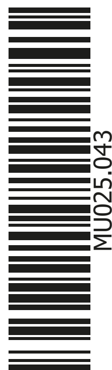
Health
Murrumbidgee
Local Health District

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _______ /_______ /_______	M.O.
ADDRESS	
LOCATION/WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE


MU025.043

REFERRAL - MH RECOVERY UNIT

The Mental Health Recovery Unit's (MHRU) vision is to support a person's unique and personal journey to wellness. This will be achieved by providing participants with diverse and varied opportunities for engagement in therapeutic and regenerative activities; adopting an optimistic and positive approach when supporting people with mental health issues to live, work and participate in their community; and planning and delivering care in partnership with key service providers, consumers, families and carers.

REFERRAL FORM PART A: REFERRER TO COMPLETE

Must be completed by the primary support person other than family/carers; such as GP, Counsellor, Support worker or Community Mental Health Teams.

REFERRAL FORM PART B: APPLICANT TO COMPLETE

Must be completed by the person seeking admission to the program.

**Please note that incomplete forms will delay progress*

ELIGIBILITY CRITERIA:

1. Are at least 16 years of age. The MHRU will be targeted at adults, however individuals who are less than 18 years of age or older than 65 years may be admitted if other inclusion criteria are met. Admission of individuals outside of the 18-65 year old age range will occur at the discretion of the Unit Clinical Director
2. Whose primary need for care is for optimisation of function and quality of life
3. Mental health related principal diagnosis
4. Have an established goal(s) for their admission
5. Demonstrate a willingness to participate in at least some aspects of the program
6. Have the cognitive abilities required to benefit from the program
7. Have been deemed likely to benefit from the program
8. Have been deemed eligible for overnight leave by the treating psychiatrist (if being admitted from an acute mental health facility); or
9. Are at risk of frequent re-admission to hospital due to their mental health issues
10. Resident within the Murrumbidgee Local Health District.

REFERRAL AND ASSESSMENT PROCESS

Referrals are reviewed weekly upon receipt of both Part A and B. Unsuccessful applicants are notified via the nominated support (Part A) in writing. Referrals that are deemed appropriate will result in an invitation to meet with the senior team for an interview and discussion of the program.

Please send referrals to:

MLHD-wwrrh-mhadmin@health.nsw.gov.au

OR

in person Mental Health Building, Wagga Wagga Rural Referral Hospital

Telephone enquiries: 02 5943 1820

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REFERRAL - MH RECOVERY UNIT

PART A – REFERRER TO COMPLETE

Referrer Information

Referrer Name.. Date ....

Service..

Address ....

Phone .... Where did you hear about the Recovery Unit?

Email.. ....

Applicant Information

Name ....

DOB.. Gender...

Phone .... Current Mental Health Care Plan? ☐ Yes ☐ No

Address .... Email...

Diagnoses

Primary Mental Health diagnosis..

When was this first diagnosed?... By who?...

Number of major relapses ....

Date of last Mental Health admission .... Duration of admission...

Physical health issues ....

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Cognitive or learning disabilities...

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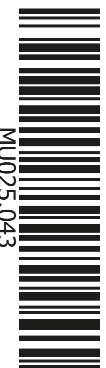

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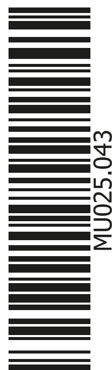

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CURRENT RISKS

Risk	Yes	No	Not known	Comments
Previous suicide attempts *(if yes please provide timeframe)*	☐	☐	☐	
Previous high lethality suicide attempts	☐	☐	☐	
Family history of suicide	☐	☐	☐	
Previous self-harm attempts *(if yes please provide timeframe)*	☐	☐	☐	
Previous threats or actual violence towards others	☐	☐	☐	
Anger is an area to be addressed?	☐	☐	☐	

Substance Use

Substance use in the past 3 months? ☐ Yes ☐ No ☐ Not known

Type and quantity per week

....

....

What involvement have you had with this person? Has your contact shown motivation, reliability and a preparedness to work on goals?..

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<u>OR</u> Attach Mental Health Review / Mental Health Assessment form or other Relevant assessments

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Medication
(or attach current Medication List

Name	Dose	Route	Frequency

Allergies

Please circle ☐ Yes ☐ No ☐ Unknown

Details...

Psychosocial Issues

Please provide further details on any of the issues that are relevant (or attach any appropriate documents):

(eg. criminal / justice issues, D & A issues, family responsibilities, custody issues)

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Please attach recent discharge summaries or mental health assessments. NSW Health eMR notes are not required.

REFERRING CLINICIAN TO COMPLETE

Name.. Signature ....

Phone.. Date...

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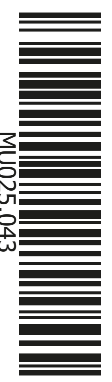

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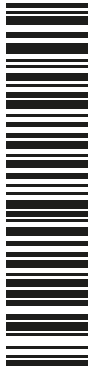

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PART B - APPLICANT TO COMPLETE

Applicant Information

Name .... Gender..

DOB... How did you find out about the Mental Health Recovery Unit?..................................

Phone .... Email...

Address ....

Is this accommodation Permanent: ☐ Yes ☐ No

Stable *(can you return to this accommodation):* ☐ Yes ☐ No

☐ Own ☐ Private Rental ☐ NSW Housing ☐ Share ☐ Boarding House ☐ Family ☐ Caravan Park ☐ Other

Next of Kin / Primary Carer Information

Name ....

Relationship...

Phone ....

Address ....

Email...

Mental Health

What is your mental health diagnosis?

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Do you have any physical health issues that impact your life? Please outline.

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Is there any equipment or extra support you may need to manage in the Recovery Unit?
(eg. shower chair, hearing aids, large print reading materials)

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Cultural Background

Country of Birth.. Preferred language..

Please circle:

Aboriginal and / or Torres Strait Islander? ☐ Yes ☐ No ☐ Not known

Is English your first language? ☐ Yes ☐ No Interpreter Required? ☐ Yes ☐ No

Justice

Intervention Order (AVO) against you: ☐ Yes ☐ No

Details...

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Do you have any current charges or court matters? ☐ Yes ☐ No

Details...

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History of criminal offences (theft, assault etc) ☐ Yes ☐ No

Details...

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Time in jail ....

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Substance Use

Have you used alcohol or other drugs in the past 3 months? ☐ Yes ☐ No

Alcohol: ☐ Yes ☐ No How much? .... How often? ....

Marijuana: ☐ Yes ☐ No How much? .... How often? ....

Stimulants: ☐ Yes ☐ No How much? .... How often? ....

Other *(please provide details)*: ....

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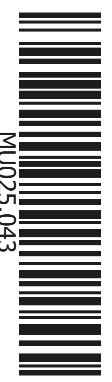
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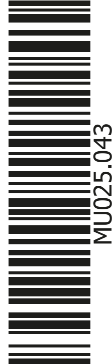

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Income / Employment

Employed: ☐ Full time ☐ Part time ☐ Casual ☐ Never worked ☐ Volunteer

☐ DSP ☐ Carer Payment ☐ Newstart ☐ Youth Allowance ☐ Other

Education Level

☐ < Year 10 ☐ Year 10 ☐ Year 12 ☐ Short Courses ☐ TAFE ☐ University

Previous Group Program Experience

Have you ever attended any Mental Health and / or Drug and Alcohol Group Programs before? ☐ Yes ☐ No

What were your achievements in these programs?

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What were the challenges?

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Describe a typical day for you

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What would you like your day to look like?

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What do you hope to achieve in the Recovery Program?

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Thoughts of Suicide or Self Harm *(if applicable)*

If you have these thoughts, how often are these thoughts occurring?

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Do you act on these thoughts? If so, how long ago? What happened?

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How will you manage these thoughts whilst in the Recovery Program?

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Living in a Close Community

What challenges will living with a diverse group of people for 2 months bring you?

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Support Services

Service	Worker Name	Email	Phone

Signature.. Date.....................................

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