TeamHEALTH Referral – Transition Care

TeamHEALTH actively promotes and supports an inclusive and diverse culture. We welcome all people, regardless of age, gender, race, ability, sexual orientation, faith, religion, and all other identities represented in our community.

Participant Details

Participant's Name _____ Preferred Name _____

Date of Birth _____ Gender _____

Email Address _____ Phone Number _____

Address _____

Country of Birth _____ Language at Home _____

Origin ☐ Aboriginal ☐ Torres Strait Islander ☐ Non-Indigenous ☐ Not Stated

Interpreter Required? ☐ No ☐ Yes

Public Guardian in Place? ☐ No ☐ Yes *Name & Phone Number:* _____

Carer in Place? ☐ No ☐ Yes *Name & Phone Number:* _____

Case Manager in Place? ☐ No ☐ Yes *Name & Phone Number:* _____

Other Services Engaged ☐ No ☐ Yes *Name & Phone Number:* _____

Name & Phone Number: _____

Name & Phone Number: _____

Referral Details

Current Mental Health Concern and/or Diagnosis:

Reason for Referral/How can TeamHEALTH support the referee?

Person Referring _____

Relationship to Participant _____

Contact Details _____

Referrer's Signature _____ Date _____

Current Medications

☐ No ☐ Yes, List: _____

_____

If yes, please attach medication chart to this referral.

Physical Health Conditions

Any physical health conditions? ☐ No ☐ Yes, List: _____

Are they independent in activities of daily living (ADL)? ☐ Yes ☐ No If no, please complete 'requires assistance with' below -

Requires assistance with:

Additional Information

NDIS Plan in Place? ☐ No ☐ Yes *Plan Number* _____

☐ Self ☐ Plan ☐ Agency Managed _____

Accessed TeamHEALTH Supports Previously? ☐ No ☐ Yes *List Services and Dates:* _____

_____

Consent

I consent to this referral. I understand that this information will be stored on the TeamHEALTH system and that my details will be de-identified if they are used in reporting.

Signature of Participant	Signature of Public Guardian (if applicable)	Date

In the absence of written consent, verbal consent was gained ☐ No ☐ Yes

Risk Assessment (Referrer to complete) OR please provide most recent comprehensive risk assessment together with discharge summary

Participant risk factors (referrer to complete)	Yes	No
History of suicide attempt/s or current suicide ideation	☐	☐
Recent traumatic life event	☐	☐
Current misuse of drugs or alcohol	☐	☐
Forensic history	☐	☐
Recent incident involving aggression/violence	☐	☐
Known use of weapons	☐	☐
Expressing intent to harm others	☐	☐
Preoccupation/hallucinations with violent or paranoid themes/ideas	☐	☐
Inappropriate sexual behaviour	☐	☐
Reduced ability to self-control / self-regulate	☐	☐
Major physical disability/illness (including infectious disease)	☐	☐
Known prejudices – ethnic, religions, other:	☐	☐
Issues with compliance e.g. appointments, medication. If yes, please detail:	☐	☐

Protective factors

Other identified risks

Supporting Information Attached

☐ Risk assessment ☐ Supervision Order ☐ Behaviour Support Plan ☐ Community Management Order

☐ Medication Chart ☐ Discharge Plan

☐ NDIS Plan

Completing this Form

Please call TeamHEALTH on 1300 780 081 if you need any assistance completing this form.

Send the completed form to: Rachel.Finlay@teamhealth.asn.au

We will respond to referrals within 24 hours or next business day to arrange an assessment.

Please include recent history/progress notes, risk assessment (as above) and discharge summary/plan

Thank you for your referral.