Uniting

Warekila Adult Mental Health Service

Service provider referral form

Important Information about your referral:

Has the person consented to this referral? Yes No

If you have answered ‘no’ to the above question, your referral may not be accepted. Please contact us to discuss further, and to explore other possible options.

If the Client requires urgent assistance, please call the Mental Health Line on 1**800 011 511,** dial **000,** or attend the nearest hospital emergency department.

Please note that this form is intended for service providers who are involved in the Client’s care. If you are seeking assistance for yourself, or are a family member or friend wanting to refer your loved one, please contact us directly on **(02) 9196 8700.**

Please be aware that receipt of the referral does not indicate acceptance to the Warekila program, and the suitability of the referral will be determined following review by our team. If you have any queries about your referral, please contact us on **(02) 9196 8700**, or at SNPHN.AdultMentalHealth@uniting.org

Information on this form will assist our team in determining suitability and facilitating the assessment process. Therefore, please provide as much information as possible, including any supporting clinical documentation available.

Learn more about the Warekila program:

- Additional information for service providers
- The role of a Warekila psychiatrist

Section 1: Client details

First name:	Last name:
Date of birth:	Country of birth:
Gender:	Gender pronoun(s):
Language spoken at home:	Interpreter language (if required):
Home address:	
Suburb:	Postcode:
Phone number:	Mobile number:
Email address:	

Section 2: Next of kin/emergency contact details

Full name:	
Relationship to Client:	
Home address:	
Suburb:	Postcode:
Phone number:	Mobile number:
Consent to liaise?	Yes No

Section 3: Health information

Presenting issues/Reasons for referral:
Please attach any additional notes, discharge summaries, assessment information

Primary and secondary diagnoses:
Please include any conditions that impact on the Client's wellbeing and functioning

Current medications/Treatments:
Please provide details

Antipsychotics	Antidepressants
Anxiolytics	Psychostimulants and nootropics
Hypnotics and sedatives	Other

Section 4: Current and previous supports

Is the Client currently, or have they previously been, engaged with any of the following providers?

Warekila routinely works with community GPs to coordinate care and at times, offer telepsychiatry appointments. For this service to be accessible, please ensure the relevant GP information and associated consent is outlined below.

Care provider type (Please tick)	Name and contact details	Consent to liaise? (Please tick)
General Practitioner		
University Counsellor		
Private Psychologist		
Homelessness Service		
Public Mental Health Service		
Psychiatrist		
Child Protection Agency		
Drug and Alcohol Service		
Employment Service		
Other		

Section 5: Demographics

Aboriginal and Torres Strait Islander status:

Aboriginal	Torres Strait Islander
Neither	Both

Marital status:

Never married	Married (registered de facto)

Divorced	Widowed	Separated

Housing status:

Sleeping rough or in non-conventional accommodation	
Short-term or emergency accommodation	Not homeless

Labour force status:

Employed	Unemployed	Not in the labour force

Employment participation:

Full-time	Part-time
N/A – not in the labour force	

Income source:

N/A – under age 16	Disability Support Pension

Other pension or benefit	Paid employment	Compensation payments
Nil income	Not known	Other

Health Care Card:

Yes	No	Unsure

NDIS involvement:

Yes	No

Section 6: Safety considerations

Risk of suicide?

Yes	No

Details:

Non-suicidal self injury?

Yes	No

Details:

Substance use?

Yes	No

Details:

Physical or verbal aggression?

Yes	No

Details:

At risk of homelessness?

Yes	No

Details:

Risk taking/Impulsive behaviours?

Yes	No

Details:

Section 7: Additional information

Please outline any additional information, history, or anything else you or the Client would like to add:

Section 8: Referring agent details

Name:	
Service/Organisation:	
Designation/Profession:	
Telephone:	Fax:
How did you hear about our service?	

Please send the completed referral form to:

Email: SNPHN.AdultMentalHealth@uniting.org

Fax: (02) 9196 8740

The referring agent will be contacted within 3 business days after receipt of the referral to discuss the next steps.

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