

Wellways to Recovery Referral Form

In collaboration with Mental Health Services Tasmania

PARTICIPANT DETAILS	
Family name:	Given names:
Date of birth:	Address:
Contact numbers:	What gender do you identify as?
Email Address:	URN (if applicable):

REFERRER DETAILS	
Referrer name:	Referral Date:
Address:	Relationship to Participant:
Organisation (If applicable):	Role at Organisation (If applicable):
Contact number:	REFERRERS SIGNATURE:
Email Address:	

MENTAL HEALTH DIAGNOSIS & CLINICAL SIGN OFF DETAILS	
DIAGNOSIS:	CLINICAL SIGNOFF:
Is the referrer the same person as the clinical sign off for the mental health diagnosis? Yes <input type="checkbox"/> No <input type="checkbox"/> If NO, please complete the below:	
Name:	Relationship to Participant:
Organisation:	Clinical Role (required):
Contact number:	Email Address:

Email referral: tasmania@wellways.org	<input type="checkbox"/> North-West	6333 3103	40 Mount Street, Burnie 7320
	<input type="checkbox"/> North	6333 3103	6-18 George Street, Launceston 7250
	<input type="checkbox"/> South	6333 3103	136 Davey Street, Hobart 7000
Has the person consented to this referral?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Has an information session occurred:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Date:	/ /

REASON FOR REFERRAL:	
<input type="checkbox"/> Managing mental health	<input type="checkbox"/> Responsibilities
<input type="checkbox"/> Relationships	<input type="checkbox"/> Social networks
<input type="checkbox"/> Physical health and self-care	<input type="checkbox"/> Identity and self esteem
<input type="checkbox"/> Addictive behaviour	<input type="checkbox"/> Work
<input type="checkbox"/> Living skills	<input type="checkbox"/> Trust and hope

PLEASE EXPLAIN THE REASON/S FOR REFERRAL INDICATED ABOVE:

HOW DOES DIAGNOSIS AFFECT PARTICIPANT (examples: relapse frequency, triggers, early warning signs etc.):
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Mental Health Order: <input type="checkbox"/> Yes <input type="checkbox"/> No	Administration/Guardianship Order: <input type="checkbox"/> Yes <input type="checkbox"/> No
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FILE IN CORRESPONDENCE

CURRENT LIVING ARRANGEMENTS:**PRESCRIBED MEDICATION:****OTHER HEALTH ISSUES (E.g., diabetes, cardiac conditions, allergies, alerts etc.):****RISKS / SAFETY ISSUES:** Please provide notes regarding all risks rated low, moderate, or high.

	NONE	LOW	MOD	HIGH	DETAILS/OTHER COMMENTS
Suicidality (thoughts, plan, intent, history)					
Risk of harm to self					
Risk of harm to others					
Risk of harm from others					
Avoiding contact					
Barriers related to culture					
Inappropriate sexual behaviours					
Disability issues					
Cognitive impairment					
Impulsive behaviours					
Forensic history					
Other vulnerabilities (i.e., financial, neglect etc.)					

COMORBIDITY ISSUES OR MISUSE (e.g., disability, alcohol, drug, gambling, hoarding):Current / recent: Yes ☐ No ☐

Type, frequency, and amount of use: _____

Does the client have relevant services involved: Yes ☐ No ☐

Please provide details: _____

FAMILY, SOCIAL SUPPORTS, COMMUNITY AGENCIES, OTHER AND/OR PETS INVOLVED:Does the person have a Mental Health Plan? Yes ☐ No ☐ If yes, please attach.Does the person have a Discharge Plan? Yes ☐ No ☐ If yes, please attach.

Other/additional comments: _____

Is the person currently with DHHS Mental Health Services? Yes ☐ No ☐