**Referral Form** 

**And Referral Guidelines**

**K & M Support Services** Maddington is a-friendly and confidential service available to people aged 0 – 80 years, in Perth metropolitan regions of Perth. **KNMSS** brings together a range of communities-based and government agencies, to provide a holistic service as a “one-stop-shop” for individuals, families and carers with physical disabilities, other disabilities and mental health distress/ challenges of all backgrounds and ages. We offer information, intake, assessment, and referral.

Services available at KNMSS are:

* Outreach and community support.
* Psycho-social supports
* Support coordination level 1&2
* Specialist Coordination
* Therapeutic supports.
* Respite care short and medium term
* Recovery Coaching

**How to refer**

**Professional Referral**

* Referrals accepted from GP’s, Allied Health Professionals, community-based agencies and educational institutions and NDIA/ Support Coordinators
* Where available, GP’s should include a copy of the client’s Mental Health Treatment Plan. Support Coordinators should include NDIS support plan.

**Self-referral**

* By phone/email: please call 0434214509 or email [info@knmss.com.au](mailto:info@knmss.com.au) (please note these are only attended/checked during business hours)
* Between 9am and 5pm, Monday – Sunday Staff will endeavour to see to participants the same day or the next available appointment will be offered

**Family Referral**

* Families, carers or friends can refer. Participants need to be aware of and consent to the referral and be willing to meet with a member of the KNMSS team

**Participant Details**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date of Referral** | | | **DOB**      /     /      **Age** | | |
| **Name** | | | **Gender** | | |
| **Address** | | | | | |
| **Email** | **Mobile** | | | **Home Phone** | |
| **NDIS/Reference No** | |  | | |  |

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| --- |
| **Are there any safety concerns when contacting the participant by phone/mail?** |
| **Consent to contact participant via: (e.g. confirm appointments etc.)**  **Mobile:**   Yes  No **Text:**  Yes  No **Voicemail:**  Yes  No  **Email:**  Yes  No **Mail:**  Yes  No **At home:**  Yes  No  **Preferred method of contact *(this can change and other arrangements can be made):*** |

|  |
| --- |
| **Language spoken at home?** |
| **Ability to speak English?**  Very well  Well  Not well  Not at all **Preferred Language** |
| **What is the participant’s cultural background?** Aboriginal  TSI  Other  Unknown |
| **Who does the participant live with?** |
| **Education/employment status?** |
| **Is the participant aware and consented to the referral?** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Next of Kin (MUST be completed if participant is under 16 unless mature minor process followed)** | | | |
| **Next of Kin name** |  | **Mobile number** |  |
| **Relationship to participant** |  | **Home number** |  |
| **Is the participant’s parent/guardian aware that this referral has been made?**  Yes  No | | | |
|  |  |  |  |

**Reason for Referral**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Presenting Issues** *(please include here any information which may be useful as background information to assist with the referral e.g. mental health, drug and alcohol, physical health & other disabilities, including past/current risk assessments)* | | | | | | | | |
| Mental health | | Physical health & other disabilities | | | Sexual health  Social support  Friendships | Alcohol/drugs  Family support | | |
| Mental health diagnosis (if relevant) | |  | (*Please attach copy of current Mental Health Treatment Plan/NDIS Support plan if available)* | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
| Duration of presenting problem | |  | | | | | | |
| **Recent Stressors** *Are there any legal proceedings pending? (please note K & M Support Services is unable to provide opinion re: legal matters or supporting documents)* | | | | | | | | |
|  | | | | | | | | |
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| **Participant History** *(Relevant biological, psychological, physical and social history, including family history)* | | | | | | | | |
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|  | | | | | | | | |
| **Relevant medications:** |  | | | | | | | |
| **Risk to self or others** *(include self-harm/suicide attempts, violence, threats of violence)*  **PLEASE NOTE: KNMSS does not provide crisis or acute care, if in crisis please refer to the closest Emergency Department or call the Mental Health Emergency Response Line (MHERL) on 1300 555 78** | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
| **Other Care Providers Involved (Previous/Current)** *(is the participant linked in with any other services? For example Allied Health Services* | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
| **Admissions to hospital related to mental health/Disability?** | | | |  | | | **If so, how many?** |  |

**Referrer Details**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** |  | | | **Relationship participant** | |  | |
| **Address** | |  | | | | | |
| **Organisation** | | |  | | **Contact Number** | |  |

**participant’s GP (if not the referrer):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** |  | | **Practice** |  |
| **Address** | |  | | |

**Consent Details**

Please indicate who is consenting to collection, use and disclosure of personal health information:

|  |  |  |  |
| --- | --- | --- | --- |
| 🞎 Adult participant | 🞎 young person (aged 16 or over) | 🞎 Parent/guardian |  |

All information will be treated confidentially and will not be used for any other purposes that what is stated in the full consent form (signed during the first appointment). I am aware that this referral is being made. I understand I can withdraw from this service at any time. The client has been made aware of this referral.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |
|  | Participant name |  |  | Participant signature |  |  | Date |  |
|  |  |  |  |  |  |  |  |  |
|  | Parent/guardian name |  |  | Parent/guardian signature |  |  | Date |  |

**Call 0434214509 or email to** [**info@knmss.com.au**](mailto:info@knmss.com.au)

Please note that KNMSS does not provide crisis or acute care mental health services.