



Referral Form

CECAT is a statewide community Mental Health Service, providing Art Therapy for youth and adults with a primary mental illness. Referrals are to be completed by either Mental Health Case Managers or the prospective participant's treating Doctor. **For confidentiality, if faxing the referral, supply only the initial of the last name and UMRN/CMHI number.**

NB: It is mandatory that the client has an active case manager and it is the responsibility of the referrer to ensure this. Referrals will not be accepted if this condition is not met.

Title	First Name:	Surname:	UMRN/CMHI:
Address:			Date of Birth:
Phone number:			Male / Female
*Diagnosis *Mandatory	*ICD Codes *Mandatory	Onset of illness:	PSOLIS Management Plan? Yes / No
Previous Therapy:		Current Therapy and treatment goals:	
General Medical & Mental Health History: Are there special concerns e.g. Hep C, HIV, epilepsy, diabetes, allergies, etc?		Current Medications and Side Effects: Medication Compliance: Yes No Inconsistent Insight into Illness: Low Medium High	
How might your client benefit from attending Creative Expression Centre?			
Would this person be able to work in small groups and socially mix with others in the studio setting?			
Are they more suited to individual work?			
How much supervision, support or structure would they need?			
Does the person have cognitive impairments and limited concentration? Are they able to follow instruction as required?			
Is this person independent in their self-care? i.e. eating, personal hygiene			

Relevant cultural issues?		
Substance abuse issues? Please complete Brief Risk Assessment form.		Drug/Alcohol agencies involved, contact person's details:
Risk: Low Medium High		
History of verbal or physical aggression? Please complete the Brief Risk Assessment. How safe would this person be working in an arts environment with sharp tools?		
Risk: Low Medium High Level of Insight: Low Medium High		
History of self harm? Note relevant details including triggers and recent occurrences.		
How safe would this person be working in an arts environment with access to sharp tools?		
Risk: Low Medium High Level of Insight: Low Medium High		
Relapse and/or hospitalisation in the last 1 to 2 years?	How many times and why?	
Please detail factors that may increase risk of relapse and / or relapse presentation features:		
Accommodation type? Transport capacity? Highest Education Level? Employment / Source of income?	Social / Leisure interests? Family or other supports? Other Care Agencies Involved?	
*Current Case Manager:	Level of contact by Case Manager?	
*Contact details:	Level of contact by treating Doctor?	
	*Mandatory	
Referred by:	Title / Qualifications:	Address: Email address:
Signature:	Date:	Contact numbers:

BRIEF RISK ASSESSMENT

SURNAME:

UMRN:

SEX:

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FORENAMES:

BIRTHDATE:

PATIENT'S ADDRESS:

SOURCE OF INFORMATION	<input type="checkbox"/> The consumer	<input type="checkbox"/> Immediate carer (parent, spouse, child)
<input type="checkbox"/> Other informants (family, friends)	<input type="checkbox"/> Previous clinical records	<input type="checkbox"/> Assessing clinician's knowledge of consumer's past behaviour/current clinical presentation
<input type="checkbox"/> Police/ambulance/other agencies	<input type="checkbox"/> Other (please specify) _____	

SUICIDALITY Static (historical) factors	Yes (1)	No (0)	Not Known	Dynamic (current) risk factor	Yes (2)	No (0)	Not Known
Previous attempt(s) on own life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Expressing suicidal ideas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous serious attempt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has plan/intent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family history of suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Expresses high level of distress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Major psychiatric diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hopelessness/perceived loss of coping or control over life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Major physical disability/illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recent significant life event	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Separated/Widowed/Divorced	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reduced ability to control self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of job/retired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Current misuse of drugs/alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PROTECTIVE FACTORS (describe) :

LEVEL OF SUICIDE RISK (total score): **LOW (<7)** **MODERATE (7-14)** **HIGH (>14)**

AGGRESSION/VIOLENCE Static (historical) factors	Yes (1)	No (0)	Not Known	Dynamic (current) risk factor	Yes (1)	No (0)	Not Known
Recent incidents of violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Expressing intent to harm others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous use of weapons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Access to available means	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Male	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paranoid ideation about others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Under 35 years old	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Violent command hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Criminal history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anger, frustration or agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous dangerous acts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Preoccupation with violent ideas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Childhood abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inappropriate sexual behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Role instability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reduced ability to control self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of drug/alcohol misuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Current misuse of drugs/alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PROTECTIVE FACTORS (describe) :

LEVEL OF VIOLENCE RISK (total score): **LOW (<7)** **MODERATE (7-14)** **HIGH**

OTHER RISKS IDENTIFIED (AND RISK FACTORS)**RISK MANAGEMENT ISSUES** (please ensure alerts are noted here)

(To be completed by assessing clinician)

PRINT NAME:**DESIGNATION:****SIGNATURE:**

(Where appropriate, management plan to be acknowledged by requesting medical practitioner)

PRINT NAME:**DESIGNATION:****SIGNATURE:****COMPLETE AND ATTACH THE PSOLIS CLIENT MANAGEMENT PLAN**