|  |
| --- |
| **REFERRAL FORM**  **CREATIVE EXPPRESSION CENTRE FOR ARTS THERAPY SERVICES** |

|  |
| --- |
| **Please forward completed referral and required documents via:** Email: [ceu@health.wa.gov.au](mailto:ceu@health.wa.gov.au)  **OR** Fax: (08) 6159 6692 **OR** Mail: CECAT Services, PO Bag 1. Claremont. WA. 6910. |

|  |
| --- |
| Thank you for referring to CECAT Services. We are a specialist mental health creative arts therapy service providing community based interventions for consumers to assist in their Recovery. We understand that both the consumer and you will have the best understanding of needs and so we ask that the referral is completed and all the requested information included. This will ensure the referral is progressed promptly. *PLEASE TICK ALL THAT APPLY* |

|  |  |
| --- | --- |
| **PLEASE COMPLETE ALL SECTIONS (please tick all that apply)** | |
| **Please answer all statements** | |
| **YES NO** | Aged between 16 and 65  Primary diagnosis of mental illness  Has ongoing support of a community mental health case manager (MH clinician/ MH worker/ GP or Psychiatrist)  Practical or emotional support can be coordinated for the consumer by case manager if in crisis  Experiences fluctuating mental state impacting on ability to engage in structured activities/ attending service  Able to work cooperatively and safely with others in a semi structured environment  Independent in self-care or access to assistance by a carer  Experiences moderate to severe developmental, pervasive learning disorders, ABI or other organic disorders requiring support  Has attended CECAT or RAS previously for less than 3 years or never attended  Experienced trauma as a child or adult impacting on their ability to cope with stress, engage with others or manage their emotions  Motivated to make changes in their life  Has the cognitive ability for symbolic / metaphoric thinking about objects/ art  Is living with a persistent and severe mental illness requiring long-term support  Accepted for NDIS funding  Experiences barriers accessing community services due to mental illness |

|  |  |
| --- | --- |
| **REASON FOR REFERRAL** | |
| REASON FOR REFERRAL: | Complex trauma  Consultation for community art options  Develop self-regulation or resilience  Improve self-esteem  Grief and loss issues  Trauma  Anxiety  Mood/ depression  Coping skills |

|  |  |  |
| --- | --- | --- |
| **INFORMATION TO BE INCLUDED WITH REFERRAL** (PLEASE MARK ALL ITEMS INCLUDED WITH REFERRAL) | | |
| Crisis Awareness Plan or Safety Plan | Consumer Expression of Interest | Current Brief Risk Assessment (BRA) |
| ICD Code - diagnosis | Current MH care plan or PSOLIS care plan | Signed Case Manager Agreement |

|  |  |
| --- | --- |
| **CONSUMER DEMOGRAPHIC INFORMATION** | |
| HOME ADDRESS: | Please use I.D. Label OR Insert Name  SURNAME:       OTHER NAMES:  DOB:       GENDER:  UMRN: |
| HOME TEL:       MOBILE: |
| CARER/ SUPPORT/ NOMINATED PERSON AND CONTACT DETAILS (If Applicable)  NAME:       TELEPHONE: |
| COMMUNITY MH CASE MANAGER NAME AND DESIGNATION:       TELEPHONE | |

|  |  |  |
| --- | --- | --- |
| **CURRENT MENTAL HEALTH TREATMENT** | | |
| TREATING PSYCHIATIST / DOCTOR NAME AND CONTACT DETAILS: | **Current ICD Code**:  Diagnoses: | |
| SIGNIFICANT TREATMENT OR MANAGEMENT ISSUES (historical/ current- including hospitalisations over last 2 years):  MEDICATIONS AND SIDE EFFECTS OF MEDICATION ON FUNCTION:  ANY EQUIPMENT/ TOOLS/ ACTIVITY RESTRICTIONS DUE TO MEDICATION: | | Forensic issues  Aggression to others  Violence to others  Impulsivity  Vulnerability to exploitation  Non-medical drug use  Homicidal/ suicidal ideation  Self-harm/ suicide attempt |

| **HEALTH ISSUES** | |
| --- | --- |
| MANAGEMENT DETAILS OF ANY ALLERGIES:  SIGNIFICANT MEDICAL ISSUES THAT IMPACT ON FUNCTION OR MOBILITY: | Acquired brain injury  Allergies  Asthma  Diabetes  Epilepsy  Other physical illness |

|  |  |  |  |
| --- | --- | --- | --- |
| **CONSUMER’S STRENGTHS** | | | |
| Acceptance of illness  Supportive family/ friends  Motivated to change | Manages some conflict  Can problem solve  Copes with change | Insightful  Takes personal responsibility  Established community links | Sense of humour  Stable accommodation  Other: |
| IMPACT ON FUNCTION: | | | |

|  |  |
| --- | --- |
| **CONSUMER’S NEEDS** | |
| UNMET FUNCTIONAL OR PSYCHOSOCIAL NEEDS: | Coping skills  Daily routine  Linking to community  Resilience  Social/ communication skills  Stress / anxiety management  Trauma counselling |

|  |  |
| --- | --- |
| **SOCIAL HISTORY / WELFARE NEEDS** | |
| UNMET SOCIAL WELFARE NEEDS: | Family issues  Relationship / friend issues  Employment/ study issues  Ongoing financial stress  Ongoing legal issues  Stable/ safe accommodation  Other : |

|  |  |  |
| --- | --- | --- |
| **SUPPORTS & CONTACTS** | **RELATIONSHIP** | **CONTACT DETAILS** (telephone and email) |
|  | MH Case Manager |  |
|  | Community GP |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| **COMPLETED BY** | | |
| PRINT NAME: | SIGNATURE | |
| DESIGNATION: | DATE: | TIME: |

**CECAT CARE COORDINATION AGREEMENT WITH CASE MANAGERS**

Consumers who attend CECAT are required to have ongoing case-management for the duration of their attendance at the service. Nominated Case Managers could be psychiatrists, mental health clinicians and GPs.

CECAT is a community service that does not have the capacity to provide crisis intervention nor emergency mental health, medical or social-welfare services to individuals. In signing this Agreement, you acknowledge that as Case Manager you will provide or coordinate the services detailed below if there is a need.

In signing this agreement I, ……………………………………… acknowledge that

I am the nominated Case Manager for ………………………………….……and will provide:

|  |  |  |
| --- | --- | --- |
| 1. Regular ongoing contact with the consumer | Yes | No |
| 1. Updated information on the consumer’s mental health, psychosocial needs, current treatment/therapy and supports | Yes | No |
| 1. Information regarding significant changes in their mental health, physical health, related risks, functioning and clinical management | Yes | No |
| 1. Coordination of clinical and/or social-welfare follow-up in emergencies / crises | Yes | No |
| 1. Information when the consumer ceases to have contact with me as Case Manager | Yes | No |

Consumer Signature: ………………………………………….……Date:…………………

Case Manager Signature: ………………………………………… Date: ………………..

Address: ………………………………………………………………………………………

Phone Number: ……………………… Email Address: …………………………………..

Please return this signed form via:

Email: [ceu@health.wa.gov.au](mailto:ceu@health.wa.gov.au)

Fax: (08) 6159 6692

Mail: CECAT Services, PO Bag 1, Claremont. WA, 6910

Or call CECAT on (08) 6159 6907 for more information

**MENTAL HEALTH COLLABORATIVE ACTION PLAN**

**(Formerly Crisis Awareness Plan)**

|  |  |  |
| --- | --- | --- |
| **NAME:** | **CASE MANAGER:** | **DATE:** |

|  |  |  |  |
| --- | --- | --- | --- |
| **NEED / FIELD** | **HOW IT CAN BE DONE AND WHAT I WANT TO HAPPEN (ACTIONS & OUTCOMES)** | | |
| 1. **STABLE PRESENTATION**   When I am well, I notice that… |  | | |
| 1. **TRIGGERS & SYMPTOMS**   Signs of me becoming unwell that I or my family, friends or others notice are… |  | | |
| 1. **SELF NURTURE**   What I can do to help myself… |  | | |
| 1. **SUPPORTS & CONTACTS** | | **RELATIONSHIP** | **CONTACT DETAILS** (telephone and email) |
|  | | MH Case Manager |  |
|  | | Community GP |  |
|  | |  |  |
|  | |  |  |
|  | |  |  |
| 1. **DE-ESCALATION & INTERVENTION**   What others can do to help me… |  | | |
| 1. **MANAGING SAFETY**   My clear wishes including community and inpatient intervention if necessary are included. If I feel unsafe to others or myself what I want to happen is… |  | | |
| 1. **UNHELPFUL APPROACHES**   My clear instructions of what actions or feedback can worsen an unstable situation are included. What is not helpful… |  | | |
| 1. **OTHER COMMENTS** |  | | |

|  |  |
| --- | --- |
| **WHO HELPED ME WRITE THIS PLAN:**  (Please specify name, relationship & contact details if not listed above) | **PLANNED REVIEW DATE:**  (Those to be involved) |

|  |  |  |
| --- | --- | --- |
| **NAME:** | **SIGNATURE:** | **DATE:** |
| **CASE MANAGER:** | **SIGNATURE:** | **DATE:** |

**CONSUMER EXPRESSION OF INTEREST**

As part of your referral to CECAT Services we ask you complete an expression of interest so we know how you would like to engage with our service. When we meet you we can further explore what you consider is important to work on.

|  |
| --- |
| MY NAME: |
| I AM AGREEABLE TO THE CECAT REFERRAL  YES  NO |

|  |
| --- |
| **I AM INTERESTED IN** |
| WRITING  PERFORMANCE (dance/ acting)  VISUAL ARTS  MUSIC  OTHER:       …......................................................................................................................................... |

|  |  |  |  |
| --- | --- | --- | --- |
| **THE AREAS I WOULD LIKE TO WORK ON AT CECAT** (TICK ALL THAT APPLY) | | | |
| MANAGING MY ILLNESS | FEELING BETTER ABOUT MYSELF | | MANAGING DEPRESSION |
| COPING BETTER | GETTING INTO STUDY | | MANAGING ANXIETY |
| DEALING WITH TRAUMA | MANAGING MY EMOTIONS | | DEVELOPING MY CREATIVITY |
| FEELING SAFE | LEARNING SOMETHING NEW | | GETTING A JOB |
| MANAGING MY ACTIONS | MANAGING DRUG/ ALCOHOL USE | | CHANGING MY THOUGHTS |
| IN ATTENDING CECAT, I WOULD LIKE TO CHANGE OR WORK ON …. | | | |
| MY SIGNATURE: | | DATE: | |

Please return this signed form via:

Email: [ceu@health.wa.gov.au](mailto:ceu@health.wa.gov.au)

Fax: (08) 6159 6692

Mail: CECAT Services, PO Bag 1, Claremont. WA, 6910

Or call CECAT on (08) 6159 6907 for more information

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| [MENTAL HEALTH SERVICE]  **BRIEF RISK ASSESSMENT** | | | | | | | SURNAME: | | UMRN: | | | | | SEX: | | | **BRIEF RISK ASSESSMENT** |
| FORENAMES: | | BIRTHDATE: | | | | | | | |
| PATIENT’S ADDRESS**:** | | | | | | | | | |
| **SOURCE OF INFORMATION** | * The consumer | | | | | | | * Immediate carer (parent, spouse, child) | | | | | | | | |
| * Other informants (family, friends) | * Previous clinical records | | | | | | | * Assessing clinician’s knowledge of consumer’s past behaviour/current clinical presentation | | | | | | | | |
| * Police/ambulance/other agencies | * 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 | |  | |  | |  | Expressing suicidal ideas | | | |  | |  | | |  |
| Previous serious attempt | |  | |  | |  | Has plan/intent | | | |  | |  | | |  |
| Family history of suicide | |  | |  | |  | Expresses high level of distress | | | |  | |  | | |  |
| Major psychiatric diagnosis | |  | |  | |  | Hopelessness/perceived loss of coping or control over life | | | |  | |  | | |  |
| Major physical disability/illness | |  | |  | |  | Recent significant life event | | | |  | |  | | |  |
| Separated/Widowed/Divorced | |  | |  | |  | Reduced ability to control self | | | |  | |  | | |  |
| Loss of job/retired | |  | |  | |  | Current misuse of drugs/alcohol | | | |  | |  | | |  |
| **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 | | |  | |  |  | Expressing intent to harm others | | |  | |  | | |  | |
| Previous use of weapons | | |  | |  |  | Access to available means | | |  | |  | | |  | |
| Male | | |  | |  |  | Paranoid ideation about others | | |  | |  | | |  | |
| Under 35 years old | | |  | |  |  | Violent command hallucinations | | |  | |  | | |  | |
| Criminal history | | |  | |  |  | Anger, frustration or agitation | | |  | |  | | |  | |
| Previous dangerous acts | | |  | |  |  | Preoccupation with violent ideas | | |  | |  | | |  | |
| Childhood abuse | | |  | |  |  | Inappropriate sexual behaviour | | |  | |  | | |  | |
| Role instability | | |  | |  |  | Reduced ability to control self | | |  | |  | | |  | |
| History of drug/alcohol misuse | | |  | |  |  | Current misuse of drugs/alcohol | | |  | |  | | |  | |
| **PROTECTIVE FACTORS** *(describe)* **:** | | | | | | | | | | | | | | | | |
| **LEVEL OF VIOLENCE RISK (total score):**  **LOW (<7)**   **MODERATE (7-14)**  **HIGH (>14)** | | | | | | | | | | | | | | | | |
| **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: DATE:** | | | | | | | | | | | | | | | | |
| (Where appropriate, management plan to be acknowledged by requesting medical practitioner)  **PRINT NAME: DESIGNATION: SIGNATURE: DATE:** | | | | | | | | | | | | | | | | |