H2H - HOSPITAL TO HOME REFERRAL IN FORM

Completed referral can be returned to:
Cassandra.masters@onedoor.org.au
Estimated Discharge date is ideally two weeks from when referral is received*

ELIGIBILITY

- ☐ Participant may need extra support on discharge
- ☐ Aged between 18 and 65
- ☐ Living in the Western Sydney LGA Blacktown, Parramatta, The Hills.
- ☐ Participant does not pose significant risk toward staff and/or others
- ☐ The Participant has agreed to a referral being made

SECTION 1: DETAILS OF PARTICIPANT

Preferred Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss	Surname:
Preferred Name/s:	Given Names:
Street Address:	
Suburb:	Postcode:
Home Phone:	Mobile:
Email:	
Date of Birth:	Gender: ☐ Male ☐ Female ☐ Other
Is the participant From a CALD Background? ☐ Yes ☐ No	Country of Birth:
	Interpreter Services Required: ☐ Yes ☐ No
Does the Person Identify Aboriginal and/or Torres Strait Islander? ☐ Yes ☐ No ☐ Not Known	Preferred Language:
Current Diagnosed Mental Illness and Approximate Date Diagnosed:	

This service has been made possible by funding from Western Sydney Primary Health Network.

Reason for current hospital admission:

Any ongoing stressors?

Reason for referral, please tick all that apply:

- ☐ Peer support (having someone to talk to)
- ☐ Assistance with Centrelink
- ☐ Assistance linking in with counsellor
- ☐ Access food hamper for discharge
- ☐ Assistance with Mental Health Care Plan
- ☐ Create schedule for daily living
- ☐ Setting and achieving personal goals
- ☐ H2H Social Club, increasing social interactions
- ☐ Assistance with Dept Housing
- ☐ Assistance linking in with Psychologist
- ☐ Support with medical appointments
- ☐ Support in managing symptoms

Other:

Please circle level of risk:

- ☐ **Suicide:** low medium high
- ☐ **Self-Harm:** low medium high
- ☐ **Aggression:** low medium high
- ☐ **Vulnerability** low medium high

If any risks are medium or high, please provide details.

Please circle any substances that are used:

- ☐ **Alcohol:** low moderate high
- ☐ **Illicit drugs**: low moderate high

Would you like assistance in abstaining from use? Yes No

Are you currently receiving support to assist in abstaining? Yes No

If yes, from which service?

Name of organisation:

Name of case manager:

Contact number:

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SECTION 2: SECONDARY CONTACT PERSON (in case of emergency or inability to contact participant directly)	
Given Names:	Relationship to Participant:
Home Phone:	Mobile:
Work Phone:	Email:

SECTION 3: HOSPITAL DETAILS	
Hospital:	Unit:
Admission Date:	Estimated Discharge Date:
Legal Status on Admission: ☐ Voluntary ☐ Involuntary	
Number of Hospital Admissions in last 12 Months:	Number of Days in Hospital Over the Last 12 Months:

SECTION 4: DETAILS OF REFERRAL	
Referrer:	Signature:
Organisation (if relevant):	Position or Relationship:
Phone:	Email:
Discharge Plan attached to this referral? Yes or No	

SECTION 4: CONSENT

I, _____ (being referred) give consent for One Door Mental Health to communicate and collect information from the referrer. I give consent for One Door Mental Health to keep a record of my referral which will remain strictly confidential and only used for its intended purpose.

Signature (Participant) _____ **Date:** / / 20

Where Verbal Consent is Provided

Signature (Referrer) _____ **Date:** / / 20

Name (Witness) _____

Signature (Witness) _____ **Date:** / / 20

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