Richmond Fellowship ACT Inc.
Pialligo and Fairbairn Aves, Pialligo ACT 2609
PO Box 1304 Fyshwick ACT 2609
Phone:(02) 6279 4900, Fax (02) 6247 7691

RICHMOND FELLOWSHIP – ADULT RESIDENTIAL RECOVERY PROGRAM
Referral Form

Date referral completed:

Person's name (being referred):

Date of birth:

Identified gender:

Beliefs and practices:

Identified ethnic background - *ATSI* *CALD:* _____ Nil (please circle)

Phone Contact:

Current address:

Eligibility for NDIS support - *Yes* *No* *In progress* (please circle)

NDIS participant number:

Eligibility for NDIS supported independent living funding (SIL): *Yes* *No* *In progress* *Unsure* (please circle)

Plan Management Agency:

REASON FOR REFERRAL TO RICHMOND FELLOWSHIP ADULT RESIDENTIAL RECOVERY PROGRAMME:

PARTICIPANT DISABILITIES:

1. **Psychosocial Disability resulting from Mental illness impacting upon the person's functional capacity**

   a. Diagnosed Mental Illness(s):

   b. Symptoms of illness:

2. **Other Disability(s):**

3. **Health and wellbeing:**
   Concerns / medical diagnoses:

   Mobility

   Alcohol and Substance use

Goals related to Supported Independent Living

1.

2.

Areas of concern, that require the person to have 24 hour supported care:

- ***Look at the following areas: mental and physical health;- relationships;- safety;-wellbeing;-personal care; household tasks***

What type of assistance does this person require to function.

1) **Personal Care Tasks**
   (including showering, maintaining hygiene, healthy diet, grooming, managing medications, keeping physically active, sleeping etc.)
   Please provide examples:

2) **Managing Home Living**
   (including cleaning, cooking, washing clothes, shopping, paying bills, maintaining tenancy, relations with neighbours etc)
   Please provide examples:

3) **Maintaining Daily Roles & Activities**
   (including going to work, managing to study, having interests, keeping occupied etc.)
   Please provide examples:

4) **Social Engagement and communicating with others**
   (including engaging with the public, getting to places, socialising, making friends, family relations, behaving appropriately, living with others, asking for help etc)
   Please provide examples:

Participants Supports: Please phone name and contact details if known.

1) **Family:**

2) **Social/Personal/Friendship Supports:**

3) **GP:**

4) **Mental Health Supports (Clinical manager, Psychiatrist):**

5) **Support Co-ordinator:**

6) **Plan manager:**

7) **External community Support: (through NDIS plan):**

8) ***Other health professions involved:***

9) ***Are they on any orders?***

Guardianship, Financial, PTO, CTO.
Please attach to referral

10) ***Income (DSP, Newstart, Trust):***

Supporting information

- Please list any hospital admissions over the past year.

- Please attach any supporting documentation(Allied health reports, Behaviour Support Plan).

Referral Form Completed by:

Relationship to Applicant:

Phone: **Email:**

Please forward this referral to amanda@rfact.org.au or katrina@rfact.org.au
ph: 6279 4900