REFERRAL for
MENTAL HEALTH RESPITE PROGRAM (MHRP)

ALL INFORMATION STRICTLY CONFIDENTIAL

DATE COMPLETED: ______________

<table>
<thead>
<tr>
<th>SECTION A - INITIAL ELIGIBILITY CHECKLIST</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Is the person:</strong></td>
</tr>
<tr>
<td>Aged 16+:</td>
</tr>
<tr>
<td>Aged less than 18 years or under legal guardianship (If yes please complete Section D)</td>
</tr>
<tr>
<td>With a carer, family member or friend who provides support (eg. Emotional, social, daily living skills etc.)</td>
</tr>
<tr>
<td>And the support person currently residing in the current catchment areas (see below for details)</td>
</tr>
<tr>
<td>Professionally assessed as having psychiatric diagnosis and/or intellectual disability, autism, aspergers syndrome or dual diagnosis</td>
</tr>
<tr>
<td>Able to make informed decisions</td>
</tr>
<tr>
<td>Willing to participate in the program</td>
</tr>
<tr>
<td>Willing to follow codes of conduct / rules of the program (see attached)</td>
</tr>
<tr>
<td>Able to look after their own personal care / needs.</td>
</tr>
<tr>
<td>Do the support person and support recipient consent to New Horizons passing on information contained in this referral to CCRC (Commonwealth Carers Respite Centre)</td>
</tr>
</tbody>
</table>

- Confirmation of diagnosis / diagnoses at point of referral or prior to commencing support is required
- Applicants must agree to the codes of conduct / rules of the program as part of referral process.
- Risk Assessment to be completed and attach additional pages if necessary

Carer Catchment Area:
□ Northern Sydney: Hornsby, Willoughby, Ku-ring-gai, Hunters Hill, Ryde, North Sydney, Mosman, Lane Cove, Pittwater, Warringah, Manly
□ Central Coast: Gosford or Wyong LGA’s (Local Government Areas)

Care Recipient Catchment Area:
□ Northern Sydney: Hornsby, Willoughby, Ku-ring-gai, Hunters Hill, Ryde, North Sydney, Mosman, Lane Cove, Pittwater, Warringah, Manly
□ Central Coast: Gosford or Wyong LGA’s (Local Government Areas)
**SECTION B – REFERRAL SOURCE**

<table>
<thead>
<tr>
<th>NAME: ___________________________</th>
<th>POSITION: ___________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGENCY NAME: ____________________</td>
<td>(If Self Referral, write “SELF” here)</td>
</tr>
<tr>
<td>TELEPHONE: ______________________</td>
<td>MOBILE: _____________________________</td>
</tr>
<tr>
<td>EMAIL: __________________________</td>
<td></td>
</tr>
</tbody>
</table>

How long has the applicant been known to you? __________________________________________

How did you find out about this service? ________________________________________________

**SECTION C – APPLICANT / CARE RECIPIENT INFORMATION**

<table>
<thead>
<tr>
<th>NAME: ___________________________</th>
<th>D.O.B: <em><strong>/</strong></em>/____</th>
<th>GENDER: ______________</th>
</tr>
</thead>
<tbody>
<tr>
<td>CURRENT ADDRESS: __________________</td>
<td></td>
<td>POSTAL ADDRESS: __________________</td>
</tr>
<tr>
<td>TELEPHONE: ______________________</td>
<td>MOBILE: __________________</td>
<td>EMAIL: __________________</td>
</tr>
<tr>
<td>ARE YOU A CARER: □ Yes □ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DETAILS: ________________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

COUNTRY OF BIRTH: __________________ | LANGUAGE(S) SPOKEN: __________________ |

INTERPRETER REQUIRED: □ Yes □ No

Does the applicant identify as being:

ATSI (Aboriginal / Torres Strait Islander): □ Yes □ No

CALD (Culturally and linguistically diverse background): □ Yes □ No

Are there any specific cultural or religious practices to be aware of? □ Yes □ No

DETAILS: ____________________________

**SECTION D - CARER / SUPPORT PERSON / GUARDIAN INFORMATION**

<table>
<thead>
<tr>
<th>NAME: ___________________________</th>
<th>D.O.B: <em><strong>/</strong></em>/____</th>
<th>GENDER: ___________</th>
<th>MARITAL STATUS: __________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>RELATIONSHIP TO CARE RECIPIENT: __________________</td>
<td>No. OF PEOPLE CARING FOR: __________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CARING DUTIES: ____________________</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ADDRESS: ________________________________________________________________

TELEPHONE: ______________________ MOBILE: ______________________ EMAIL: ______________________

RECEIVING PENSION: □ YES □ NO TYPE: __________________

COUNTRY OF BIRTH: __________________ | LANGUAGE(S) SPOKEN: __________________ |

INTERPRETER REQUIRED: □ Yes □ No

Does the applicant identify as being:

ATSI (Aboriginal / Torres Strait Islander): □ Yes □ No

CALD (Culturally and linguistically diverse background): □ Yes □ No

Are there any specific cultural or religious practices to be aware of? □ Yes □ No

DETAILS: ____________________________
PLEASE NOTE: If the applicant is under the age of 18 years or under legal guardianship then the parent / guardian must sign Section L - Consent.

SECTION E – EMERGENCY CONTACTS

1. NAME: ___________________________ RELATIONSHIP: ___________________________
   ADDRESS: ___________________________
   TELEPHONE: ______________________ MOBILE: ______________________

2. NAME: ___________________________ RELATIONSHIP: ___________________________
   ADDRESS: ___________________________
   TELEPHONE: ______________________ MOBILE: ______________________

SECTION F – MENTAL HEALTH

PRIMARY PSYCHIATRIC DIAGNOSIS: ___________________________

OTHER PSYCHIATRIC DIAGNOSES: ___________________________

CONFIRMATION OF DIAGNOSIS (eg. Attached Letter): □ Yes □ No

BRIEF HISTORY: ____________________________________________

SYMPTOMS, TRIGGERS, SUPPORT STRATEGIES, SIGNS OF ESCALATION, ETC: ____________________________________________

BEHAVIOURAL / AGGRESSION ISSUES: ___________________________

SECTION G – PRIMARY HEALTH

HEALTH CONDITIONS (eg. Diabetes, Epilepsy, Asthma, etc.): ____________________________

OTHER DISABILITIES (eg. Physical, Intellectual, ABI, ASD, etc.): ____________________________

CONFIRMATION OF DIAGNOSIS (eg. Attached Letter): □ Yes □ No

OTHER ISSUES (eg. Drug & Alcohol, Gambling, Other Dependency Issues, etc.): ____________________________
SECTION H – CURRENT CLINICAL / MEDICAL SUPPORTS

1. NAME: ___________________________________________ POSITION: ________________________________

AGENCY NAME: __________________________________________________________________________________

TELEPHONE: ___________________ MOBILE: ___________________ FAX: ______________________________

EMAIL: ________________________________________________________________________________________

BRIEF HISTORY: ______________________________________________________________________________

______________________________________________________________________________________________

2. NAME: ___________________________________________ POSITION: ________________________________

AGENCY NAME: __________________________________________________________________________________

TELEPHONE: ___________________ MOBILE: ___________________ FAX: ______________________________

EMAIL: ________________________________________________________________________________________

BRIEF HISTORY: ______________________________________________________________________________

______________________________________________________________________________________________

SECTION I – OTHER CURRENT SUPPORTS

1. NAME: ___________________________________________ POSITION: ________________________________

AGENCY NAME: __________________________________________________________________________________

TELEPHONE: ___________________ MOBILE: ___________________ FAX: ______________________________

EMAIL: ________________________________________________________________________________________

BRIEF HISTORY: ______________________________________________________________________________

______________________________________________________________________________________________

2. NAME: ___________________________________________ POSITION: ________________________________

AGENCY NAME: __________________________________________________________________________________

TELEPHONE: ___________________ MOBILE: ___________________ FAX: ______________________________

EMAIL: ________________________________________________________________________________________

BRIEF HISTORY: ______________________________________________________________________________

______________________________________________________________________________________________

3. NAME: ___________________________________________ POSITION: ________________________________

AGENCY NAME: __________________________________________________________________________________

TELEPHONE: ___________________ MOBILE: ___________________ FAX: ______________________________

EMAIL: ________________________________________________________________________________________

BRIEF HISTORY: ______________________________________________________________________________

______________________________________________________________________________________________
SECTION J – REASON FOR REFERRAL & DETAILS OF SUPPORT NEEDS

Please discuss how the applicant’s mental health diagnosis and any other disabilities / health conditions / barriers impact on their ability to achieve personal goals, manage daily activities, participate in the community, etc. Describe how MHRP could assist and support the applicant, including any areas of interest / activities that the applicant would like to engage in and strengths that the applicant possesses:

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

SECTION K – ADDITIONAL INFORMATION / COMMENTS

*Please attach any additional information, plans, reports, etc, that will help provide assistance and support to the individual.

Please complete attached risk assessment report.

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
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____________________________________________________________________________________________
____________________________________________________________________________________________
CONTRIBUTIONS

The New Horizons Mental Health Respite Program is fully funded by the Federal Government. There are no fees attached to accessing this service. However, we do encourage a small contribution ($5 per visit) to cover day to day running costs.

- I acknowledge and agree to make a contribution to the best of my ability

The information contained in this referral is complete and factual.

CARER’S/GUARDIAN’S SIGNATURE: ___________________________ DATE: _______________

APPLICANT’S SIGNATURE: ___________________________ DATE: _______________

REFERRER’S SIGNATURE: ___________________________ DATE: _______________

SECTION L - CONSENT

I, ________________________________________, understand that, in providing a service to me you may need to share relevant information with other service providers and to report on unidentifiable information for data collection. I consent to the use of information in this referral being used accordingly.

_________________________________________________________ DATE: _______________

SIGNATURE OF CARER

_________________________________________________________ DATE: _______________

SIGNATURE OF APPLICANT

_________________________________________________________ DATE: _______________

SIGNATURE OF GUARDIAN (If Applicable)

* The Privacy Act requires the applicant or person responsible to sign this form giving their consent for the release of their information and detail.
* The referrer and applicant agree that no information has been withheld and that all information provided is accurate, correct and necessary for New Horizons Enterprises Limited to provide a Duty of Care to the Applicant and meet its obligations to staff and volunteers.

* Please forward completed form, attachments and any other relevant supporting documentation to relevant location:

Mental Health Respite Program
New Horizons
Central Coast
62-64 William Street
Gosford NSW 2250
Phone: 02 4372 9800
Fax: 02 4322 7944
Email: icobner@newhorizons.net.au

Mental Health Respite Program
New Horizons
Northern Sydney
Unit 2/2A railway Parade
Thornleigh NSW 2120
Phone: 02 9875 3205
Fax: 02 9484 8516
Email: stap@newhorizons.net.au
OFFICE USE ONLY

Date Referral Received: _______________  Received By: ______________________

Respite Staff Member to Follow Up: ______________________________

Contact by Phone:  Referral Source □ YES  □ NO  Date: ________________
   Carer           □ YES  □ NO  Date: ________________
   Applicant      □ YES  □ NO  Date: ________________

Applicant/Care Recipient Assessed □ YES  □ NO  Date: ________________

Confirmation of Diagnosis: □ YES  □ NO  Date: ________________

ELIGIBILITY:

   Carer          □ YES  □ NO
   Applicant/Care Recipient □ YES  □ NO

PRIORITY OF SERVICE:

   Carer 60 years or over  □ YES  □ NO
   ATSI Carer 45 years or over □ YES  □ NO
   CALD Carer            □ YES  □ NO

Accepted into Program: □ YES  □ NO  Date: ________________
   (If No state Reason): __________________________________________

CCRC Funding Approved: □ YES  □ NO  Date: ________________

Participant Entered: Database  Date: ________________
   Carelink+        Date: ________________
<table>
<thead>
<tr>
<th><strong>NAME:</strong></th>
<th></th>
<th><strong>Date Completed:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Issue:</strong> Please circle Yes (Y) or No (N) for each risk category. If Yes please tick low, medium or high category box. Examples of low/moderate/high are listed for each category.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Risk of Aggression / Behavioural Issues:</strong></td>
<td>Y</td>
<td>Category</td>
</tr>
<tr>
<td>Low: irritable, verbally abusive</td>
<td>☐ Low</td>
<td>☐ Mod</td>
</tr>
<tr>
<td>Mod: property damage</td>
<td>☐ Low</td>
<td>☐ Mod</td>
</tr>
<tr>
<td>High: assaults other people</td>
<td>☐ Low</td>
<td>☐ Mod</td>
</tr>
<tr>
<td><strong>Risk to Physical Health / Mental Health:</strong></td>
<td>Y</td>
<td>☐ Low</td>
</tr>
<tr>
<td>Low: poor diet, non-attendance to GP</td>
<td>☐ Low</td>
<td>☐ Mod</td>
</tr>
<tr>
<td>Mod: refusal to follow up diagnosed conditions Eg diabetes.</td>
<td>☐ Low</td>
<td>☐ Mod</td>
</tr>
<tr>
<td>High: serious health problem, not co-operating with treatment</td>
<td>☐ Low</td>
<td>☐ Mod</td>
</tr>
<tr>
<td><strong>Risk of Self Harm</strong></td>
<td>Y</td>
<td>☐ Low</td>
</tr>
<tr>
<td>Low: No real suicide plan or ideation</td>
<td>☐ Low</td>
<td>☐ Mod</td>
</tr>
<tr>
<td>Mod: At risk behaviours Eg slashing</td>
<td>☐ Low</td>
<td>☐ Mod</td>
</tr>
<tr>
<td>High: Suicide plan, suicidal behaviours</td>
<td>☐ Low</td>
<td>☐ Mod</td>
</tr>
<tr>
<td><strong>Potential for Social Disruption</strong></td>
<td>Y</td>
<td>☐ Low</td>
</tr>
<tr>
<td>Low: loud noise, poor sleep pattern</td>
<td>☐ Low</td>
<td>☐ Mod</td>
</tr>
<tr>
<td>Mod: intrusive towards others, offensive behaviour</td>
<td>☐ Low</td>
<td>☐ Mod</td>
</tr>
<tr>
<td>High: intrusiveness results in conflict, violence</td>
<td>☐ Low</td>
<td>☐ Mod</td>
</tr>
<tr>
<td><strong>Risk of Isolation</strong></td>
<td>Y</td>
<td>☐ Low</td>
</tr>
<tr>
<td>Low: minimal social supports, but basic needs met.</td>
<td>☐ Low</td>
<td>☐ Mod</td>
</tr>
<tr>
<td>Mod: dissatisfaction with lack of social contact.</td>
<td>☐ Low</td>
<td>☐ Mod</td>
</tr>
<tr>
<td>High: withdrawn effects mental health</td>
<td>☐ Low</td>
<td>☐ Mod</td>
</tr>
<tr>
<td><strong>Drug and Alcohol Issues</strong></td>
<td>Y</td>
<td>☐ Low</td>
</tr>
<tr>
<td>Low: loss of self-control, not seriously addicted</td>
<td>☐ Low</td>
<td>☐ Mod</td>
</tr>
<tr>
<td>Mod: craving or dependence on alcohol/drugs,</td>
<td>☐ Low</td>
<td>☐ Mod</td>
</tr>
<tr>
<td>High: incapacitated by alcohol/drugs.</td>
<td>☐ Low</td>
<td>☐ Mod</td>
</tr>
<tr>
<td><strong>Risk of Vulnerability</strong></td>
<td>Y</td>
<td>☐ Low</td>
</tr>
<tr>
<td>Low: gives away money, cigarettes.</td>
<td>☐ Low</td>
<td>☐ Mod</td>
</tr>
<tr>
<td>Mod: fails to seek help.</td>
<td>☐ Low</td>
<td>☐ Mod</td>
</tr>
<tr>
<td>High: exploited by others physically, emotionally and/ or sexually.</td>
<td>☐ Low</td>
<td>☐ Mod</td>
</tr>
<tr>
<td><strong>Risk to Safety</strong></td>
<td>Y</td>
<td>☐ Low</td>
</tr>
<tr>
<td>Low: failure to lock front door.</td>
<td>☐ Low</td>
<td>☐ Mod</td>
</tr>
<tr>
<td>Mod: fire risks Eg leaves stove on, cigarettes burning.</td>
<td>☐ Low</td>
<td>☐ Mod</td>
</tr>
<tr>
<td>High: blatant disregard to safety, irresponsible behaviour.</td>
<td>☐ Low</td>
<td>☐ Mod</td>
</tr>
</tbody>
</table>

**Score:** Add total ticks for each category

Low Risk = Moderate Risk = High Risk =
MENTAL HEALTH RESPITE PROGRAM (MHRP)
CODES OF CONDUCT & RULES

All participants, carers, visitors, volunteers and staff of New Horizon’s Mental Health Respite Program (MHRP) are expected to comply with the following:

CODES OF CONDUCT:

- Treat others equally and fairly, with dignity and compassion.
- Respect the rights and responsibilities, privacy and confidentiality, of others.
- Treat others without discrimination or harassment of any kind.
- Maintain the safety of themselves, and others, and
- Treat the premises, furniture, equipment and property of New Horizons, and others, with respect.

In addition, they will abide by the following:

RULES FOR CENTRE BASED SUPPORT:

- Sign in when entering, and leaving, the premises.
- Refrain from physical or verbal abuse of others.
- Behave appropriately at all times.
- Maintain a reasonable level of personal hygiene.
- Do not bring weapons of any kind to the premises.
- Do not attend under the influence of, or in possession of, alcohol or illegal drugs.
- Do not smoke on the premises, except in designated areas.
- Do not attend the program if drug affected (including significant side effects of prescription medication).
- Do not attend if physically unwell, for example with the flu.

In regards to other forms of support (eg. In-Home, Community) the following will also apply:

ADDITIONAL RULES FOR OTHER SUPPORT TYPES:

- Do not have on the person or unsecured in home, weapons of any kind.
- In Home support will be ceased if other individuals and/or animals are present without discussions / arrangement being made prior to receiving support.
- Do not be under the influence of alcohol or illegal drugs.
- Refrain from smoking in enclosed areas or in close proximity of CSWs (community Support Workers).
- Support may be ceased if drug affected (including significant side effects of prescription medication).
- Support may be ceased if physically unwell, for example with the flu.

*Adhering to these Codes of Conduct & Rules are a key requirement for receiving support for Mental Health Respite Program. Any breach of these may result in withdrawal of support/service, suspension from the program and where applicable and notification to the appropriate authorities.