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| **REFERRAL FORM**  **CREATIVE EXPPRESSION CENTRE FOR ARTS THERAPY (CECAT)** |

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| This referral must be completed by a psychiatrist, treating doctor or clinical case manager who is currently providing care for the client. Ongoing involvement with a public or private mental health service and case management/care co-ordination is essential for the duration of a consumer’s engagement with CECAT. Consumers cannot be accepted without a psychiatrist, treating doctor or case manager managing their mental health care.  We understand that both the client and treating professional will have the best understanding of the consumer’s needs and therefore require that **all sections must be completed**. Please attach any other additional reports or documentation that will assist in the referral screening and assessment process. Referral Forms can be downloaded from our website. |

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| **PLEASE COMPLETE ALL SECTIONS** | | | | | | |
| **DEMOGRAPHICS:** | | | | | | |
| **SURNAME:** | | **FIRST / OTHER NAMES:** | | | | UMRN: |
| **SEX:** □M □F □Other | | **IDENTIFIED GENDER:** | | | | **DOB:** |
| **ADDRESS:** | |  | | | |  |
| **PHONE / MOBILE**: | | **EMAIL:** | | | |  |
| **COUNTRY OF BIRTH:** | |  | | | |  |
| **NEXT OF KIN:** | | | | | | |
| **NAME:** | | | | **RELATIONSHIP:** | | |
| **PHONE:** | | | | **EMAIL:** | | |
|  | | | |  | | |
| **ADDRESS:** | | | |  | | |
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| **REASON FOR REFERRAL TO CECAT – Please refer to the Eligibility Criteria** | | | | | | | | |
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| **PSYCHIATRIC DIAGNOSIS – Please include ICD 10 Code** | | | | | | | | |
| **DIAGNOSIS:** | | | | | | | | |
| **ICD 10 CODE/S:** | | | | | | | | |
| **PSYCHIATRIC / MENTAL HEALTH HISTORY (Please include information regarding hospitalisations over the last 2 years)** | | | | | | | | |
|  | | | | | | | | |
| **TREATING PSYCHIATRIST / DOCTOR NAME AND CONTACT DETAILS** | | | | | | | | |
| NAME: | | CLINIC: | | | | | | |
| PHONE: | | FAX: | | EMAIL: | | | | |
| **CASE MANAGER NAME AND CONTACT DETAILS** | | | | | | | | |
| NAME:  PHONE:  EMAIL: | | CLINIC:  FAX: | |  | | | | |
| **CURRENT RISK FACTORS (Please provide relevant details)** | | | | | | | |
| □ Suicide Risk  □ Deliberate self harm  □ Alcohol misuse  □ Drug misuse  □ Forensic history or history of aggression | | | | | | | |
| **TRIGGERS & WARNING SIGNS OF RELAPSE ~~/~~** | | | | | | | |
|  | | | | | | | |

| **RELEVANT MEDICAL HISTORY (General Medical History and physical disabilities)** | | | |
| --- | --- | --- | --- |
| GENERAL MEDICAL HISTORY:  PHYSICAL DISABILITIES:  ALLERGIES & MANAGEMENT:  SIGNIFICANT MEDICAL ISSUES & DISABILITIES THAT IMPACT ON FUNCTION OR MOBILITY: | | | |
| **CURRENT MEDICATIONS & RESTRICTIONS** | | | |
| MEDICATIONS AND SIDE EFFECTS OF MEDICATION ON FUNCTION: | | | |
| ANY EQUIUPMENT/TOOLS/ACTIVITY RESTRICTIONS DUE TO MEDICATION/S: | | | |
| **OTHER CURRENT TREATMENTS / THERAPIES** | | | |
|  | | | |
| **CURRENT SOCIAL SITUATION** | | | |
| CURRENT LIVING SITUATION:  EDUCATION / EMPLOYMENT:  RELATIONSHIPS: | | | |
| **ABLE TO USE PUBLIC TRANSPORT  YES  NO PERSONAL VEHICLE  YES  NO** | | | |
| **NAME OF SUPPORTS & ORGANISATIONS INVOLVED IN CARE** | **RELATIONSHIP** | **CONTACT DETAILS (telephone, address and email**) | |
| Eg. NDIS - Provider | NDIS Care Coordinator |  | |
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| **CONSUMER CONSENT** | | | |
| This referral has been discussed with me and I am aware that there may be a waiting list for therapy at CECAT. | | | |
| PRINT NAME: | CONSUMER SIGNATURE: | | DATE: |
| **REFERRED BY** | | | |
| PRINT NAME: | SIGNATURE | | DATE: |
| DESIGNATION: | ORGANISATION: | | TIME: |
| ADDRESS: | PHONE NUMBER: | |  |

**MENTAL HEALTH COLLABORATIVE ACTION PLAN**

**(Formerly known as Crisis Awareness Plan)**

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| --- | --- | --- |
| **CONSUMER 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) |
|  | | Eg. MH Case Manager |  |
|  | |  |  |
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|  | |  |  |
| 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) |

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

**CREATIVE EXPRESSION CENTRE FOR ARTS THERAPY**

**CASE MANAGEMENT / CARE COORDINATION AGREEMENT**

Consumers who attend CECAT must have their mental health care managed by a psychiatrist or GP for the duration of their engagement with CECAT. Nominated Case Managers or Care Coordinators could be mental health clinicians or specialist support coordinators who are part of the consumers treating team.

CECAT is a community mental health therapeutic service that does not have the capacity to provide crisis intervention, medical or social-welfare services. In signing this Agreement, you acknowledge that you will coordinate the services detailed below should there be a need. Failure to meet the terms of this Agreement may result in deactivation of the consumer from CECAT.

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, 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 medical, clinical and/or psychosocial follow-up in emergencies / crises | Yes | No |
| 1. Information when the consumer ceases to have contact with me as Case Manager | Yes | No |

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

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

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

**Consumer Agreement**

I agree to :

1. Being case managed by ……………………………….  Yes  No
2. Have regular ongoing contact with my treating doctor

for the duration of my engagement with CECAT  Yes  No

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

Please return the signed forms to:

Email: [ceu@health.wa.gov.au](mailto:ceu@health.wa.gov.au) Fax: (08) 6159 6692

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

Or call CECAT on (08) 6/159 6907 for more information