Early Intervention Recovery Program
Referral Form

Date	

Overview

The MIFWA Early Intervention Recovery Program is funded by the Mental Health Commission of WA to work alongside individuals aged between 16 to 30 years, within in the Perth Metropolitan who have recently experienced their first episode/or emerging mental health to achieve their recovery goals.

Inclusion/Exclusion Criteria

☐ Between the ages of 16-30.
☐ Experienced a recent episode/or emerging mental health in the last two years.
☐ Willingness to participate in goal setting and the development of a goal plan.
☐ No NDIS plan.
☐ Not currently receiving any community peer psychosocial support.

Personal Details			
Surname	Name	D.O.B.	
Phone	Address		
Email			
Aboriginal or Torres Strait Islander ☐ Yes ☐ No	CALD ☐ Yes ☐ No Country of origin	Gender I identify as Pronouns	Preferred contact method ☐ Phone call ☐ Text/SMS ☐ Email

Carer/Guardian/Emergency Contacts		
Legal carer/guardianship order? ☐ Yes ☐ No	Name	Contact No
Name	Relationship	Contact No
Name	Relationship	Contact No

Mental Health Care Professional Details	
Name	Organisation & Role
Phone	Email

Mental Health Information

Primary and secondary diagnosis (including dates of diagnosis/hospital admission). Is the early episode related to drug induced psychosis? If yes, please provide details.

Current medications and side effects

Is the participant involved with any other health care professionals/services (e.g., GP, headspace)? If so, who?

What type of support would you / the participant benefit from the most? (Tick all relevant)

Psychological Support

☐ Managing A Budget
☐ Managing Accommodation
☐ Independent Living Skills
☐ Identifying & Using Community Facilities
☐ Employment / Education
☐ Other:

Health & Recreation

☐ Stress Management & Relaxation
☐ Groups
☐ Sporting & Recreation Programs
☐ Arts/ Crafts Activities / Hobbies
☐ Other:

Are there any specific triggers which cause you (the participant) to get stressed and/or upset?

Other comments (level of insights, concentrations, motivation etc.)

Consent (Please note without this completed, we cannot arrange an initial visit)	
☐ I agree to participate in the Early Intervention Program and understand it is not a crisis service. ☐ My parents/guardian (if applicable) agree for me to participate within the program and understand it is not a crisis service. ***This person must sign below and be listed in the carer/emergency contact section*** ☐ I agree for my referrer to share relevant information whilst receiving treatment and for referral purposes.	
Young Person Signature	Date
Parent/Guardian Signature (if applicable)	Date

Referral Completed By	
Name, Title/Qualification	Clinic/hospital
Phone	Email
Signature	

Following acceptance of this referral, a comprehensive needs assessment will be arranged to ascertain suitability for the program.

Risk Assessment Form – Early Intervention Recovery Program

	Date of Completion
Participant Name	Date of Birth

Information Obtained From:

☐ EIRP Individual/Participant ☐ Carer ☐ Formal Supports (Family)
☐ Informal Supports (Friends) ☐ Referring Practitioner ☐ Other:

Self-Harm/Suicide	YES	NO	D/K
Previous/current attempt(s) on their lives	☐	☐	☐
Family history of suicide	☐	☐	☐
Expressing suicidal ideas	☐	☐	☐
Have a suicide plan	☐	☐	☐
Expressing high levels of distress	☐	☐	☐
Self-injury (e.g. cutting, burning)	☐	☐	☐
Hopelessness/perceived loss of coping or control over life	☐	☐	☐
Other. Please specify:			

If yes to any above, please provide detailed information (i.e., occurrence, thoughts/actions and outcomes) and current protective factors/safety plan to each point separately.

Aggression/Violence	YES	NO	D/K
Previous incidents of violence (including dangerous acts)	☐	☐	☐
Expressing/expressed intent to harm others	☐	☐	☐
Intruding/commanding voices	☐	☐	☐
Harassment of/aggression towards others	☐	☐	☐
Sexually inappropriate behaviour	☐	☐	☐
Forensic history	☐	☐	☐
Other: Please specify:			

If yes to any above, please provide detailed information (i.e., occurrence, thoughts/actions and outcomes) and current protective factors/safety plan to each point separately.

Drugs and Alcohol Misuse Have you ever used?	YES	NO	In the last two (2) months, how often have you used? Once/Twice	Monthly	Weekly	Daily
Tobacco products	☐	☐	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐	☐	☐
Amphetamines	☐	☐	☐	☐	☐	☐
Cannabis	☐	☐	☐	☐	☐	☐
Cocaine	☐	☐	☐	☐	☐	☐
Hallucinogens	☐	☐	☐	☐	☐	☐
Inhalants	☐	☐	☐	☐	☐	☐
Opioids	☐	☐	☐	☐	☐	☐
Prescribed medication (misuse)	☐	☐	☐	☐	☐	☐
Other. Please specify:			☐	☐	☐	☐

Are you currently linked with an AoD Counselling Service?

☐ Yes ☐ No	AoD Counselling Service:	
Would like to be linked?	☐ Yes ☐ No	

Environment/Other	**YES**	**NO**	**D/K**
Family domestic violence (past or present)	☐	☐	☐
Medication non-compliance	☐	☐	☐
Pets at home	☐	☐	☐
Lives with others	☐	☐	☐
If, so whom?			
Physical disability	☐	☐	☐
Other: Please specify:			

If yes to any above, please provide detailed information and current protective factors/safety plan to each.

Completed by		Contact no	
Email address			
Position			
Signature			

Please ensure the referral and risk assessment forms are all completed and emailed to eirp@mifwa.org.au