

## Acacia Community Mental Health Referral form

Acacia Community Mental Health is a free mental health service provided by Anglicare WA for people aged 16 years and above. The program delivers integrated and coordinated mental health interventions and support to address the needs of various levels of mental ill-health.

ACMH is not a crisis service. If immediate action is required, please contact relevant crisis support or emergency services. Contact will be made within 7 working days of receiving this referral.

Your information is protected in accordance with the Privacy Act 1988. For further information visit [www.anglicarewa.org.au/privacy](http://www.anglicarewa.org.au/privacy)

### Service user details

First name:	Last name:
Preferred name:	Date of Birth:
Gender: <input type="checkbox"/> female <input type="checkbox"/> male <input type="checkbox"/> non-binary <input type="checkbox"/> self describe-	Pronouns: <input type="checkbox"/> she/her <input type="checkbox"/> he/him <input type="checkbox"/> they/them <input type="checkbox"/> self describe-
Is an interpreter required? <input type="checkbox"/> no <input type="checkbox"/> yes	If yes, which language:

Cultural background:

Aboriginal   Torres Strait Islander   Prefer not to say   other

Language group:

Cultural background:

Cultural, spiritual or community connections important to care:

Address:

Phone number:	Email address:
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Contact preference: phone call   SMS   email

### Referrer details

Referrer name:		Date of referral:
Phone number:	Email address:	
Referring organisation:		
Relationship to service user:	Permission to contact referrer: <input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Next of kin/ emergency contact details</b> An emergency contact may be contacted only in urgent or safety related situations		
Contact name:	Phone number:	
Relationship to service user:		
<b>Risk/ safety concerns</b> If immediate assistance is required please call 000		
Please indicate <input type="checkbox"/> self-harm <input type="checkbox"/> suicidal ideation <input type="checkbox"/> suicidal behaviours <input type="checkbox"/> violence/aggression <input type="checkbox"/> psychosis/mania <input type="checkbox"/> substance use/abuse <input type="checkbox"/> abuse/neglect <input type="checkbox"/> court orders/VROs <input type="checkbox"/> overcrowding/homelessness		
Please provide details of above concern/s:		
<b>*If there is known risk to self or others, please attach or summarise the current safety plan.</b>		
<b>Reason for referral</b>		
Brief description of current mental health concerns and why support is being requested:		

What does the service user hope to gain from this support (in their own words if possible):

Relevant mental health history:

Previous mental health supports or treatments, if known:

Current or previous diagnoses (if relevant and consented):

Are there any considerations related to past healthcare experiences that may affect engagement (if the person chooses to share):

### Consent and confidentiality

Service user agrees to referral: yes no

Consent to store personal information, such as contact details: yes no

Service user name:

Signature:

Date:

### Referrer declaration

I confirm that the information provided in this referral is accurate to the best of my knowledge and that consent has been obtained as recorded above.

Referrer name:

Signature:

Date:

**Please email the completed referral form to: [acmh@anglicarewa.org.au](mailto:acmh@anglicarewa.org.au)**

**Please attach any relevant documents, such as: care plans, safety plans, discharge summaries etc**