Early Intervention Recovery Program

Individual Referral Form

Referral 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
☐ Resides between Cockburn (south) to Joondalup (north) to Midland (East) to the west coast
☐ No NDIS plan
☐ Not currently receiving any community peer psychosocial support

My Info

Personal Details			
Surname	First Name	D.O.B	
Contact no Email	Address (including Postcode)		
Aboriginal or Torres Strait Islander ☐ Yes ☐ No	CALD: ☐ No ☐Yes 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/Role	Contact No
Name	Relationship	Contact No
Name	Relationship	Contact No

Mental Health Care Professional Details			
Name		Organization /Role	
Phone			
Email			

Early Intervention Recovery Program

Participant Application Form

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 Areas)

Psychological Support	*Health & Recreation*
☐ Managing A Budget	☐ Stress Management & Relaxation
☐ Managing Accommodation	☐ Groups
☐ Independent Living Skills	☐ Sporting & Recreation Programs
☐ Identifying & Using Community Facilities	☐ Arts/ Crafts Activities / Hobbies
☐ Employment / Education	☐ Other:
☐ 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 to me participating within the program and understand that 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.	☐
Signature:	Date:
Parent/Guardian Signature (if applicable):	Date:

Referral Completed By

Name (and Title/Qualification)	Clinic/Hospital
Contact Number	
Email	
Signature	

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

Mental Illness Fellowship of WA
Tel: 9237 8900
Website: www.mifwa.org.au

Early Intervention Recovery Program

Risk Assessment Form

		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

Mental Illness Fellowship of WA
Tel: 9237 8900
Website: www.mifwa.org.au

Early Intervention Recovery Program

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	AoD Counselling Service -	
No	Would like to be linked	

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 email to teameirp@mifwa.org.au.

Mental Illness Fellowship of WA
Tel: 9237 8900
Website: www.mifwa.org.au