Government of Western Australia
North Metropolitan Health Service
Mental Health, Public Health and Dental Services

EMR504890

Adult Hospital in the Home Referral Form

Referrals will be processed 7 days a week between 8.30am and 5pm. Referrals should be discussed with the HiTH intake officer (Weekdays) and Nurse in charge (weekends) before they will be accepted.

Patient Referral Information		
Date of referral:		**Patient Details:** *affix patient sticker here* **UMRN:** **DOB:** **Name:** **Address:** **Phone:**
Anticipated discharge date *(Inpatients only)*:		
Gender:		
Primary language and communication requirements: ☐ Interpreter required		**Next of Kin/Guardian/Support person Details:** **Name:** **Phone:** **Relationship:**
Referral discussed with HITH? Yes No Name:		

Adult HITH Admission Requirements		
Y	N	Person has been recently assessed by doctor or mental health clinician: **Date:**
Y	N	Meets admission criteria
Y	N	Consents to admission and daily participation with HITH
Y	N	Patient has a mental health condition with an acute deterioration
Y	N	Resides in NMHS catchment area
Y	N	Accommodation stable for next 14 days
Y	N	Home environment suitable and safe for mental health care to be provided in the home
Y	N	Risk of violence, aggression or self-harm can be managed in a community setting
Y	N	Physical health co-morbidities stable or have plans in place

Referral Details

Referral Details
Presenting problems requiring admission: (summarise main points including allied health needs and include ICD-10 diagnosis if available)
CTO details: (if applicable – include responsible psychiatrist and practitioner, CTO details and key dates)

Adult Hospital in the Home
Send referrals to: **email** MHPHDSAdultHITH@health.wa.gov.au **fax** 6383 4283
Intake phone: 6383 1120 **Forms available from:** Adult HiTH intranet or internet pages

Purpose of HITH referral and desired outcomes for admission: (Can include consumer and family member/carer perspectives)

Details of other services involved or referrals made: (e.g. Community Clinic, GP, NGOs)

Medical history: (include allergies, current treatments and any physical health requirements)

Current medications:

Provided Paperwork: please provide with referral or tick if available

Not available on PSOLIS: please provide scanned copies with referral of appropriate documents

- ☐ Mental health assessment
- ☐ Community visiting risk assessment tool
- ☐ Recent MSE
- ☐ Copies of last medical review from clinical notes
- ☐ Care transfer summary
- ☐ Recent physical health examination

Available on PSOLIS, Best Practice or NACs: please tick those which apply but do not send

- ☐ BRA/RAMP
- ☐ Current care plan
- ☐ Collaborative action plan
- ☐ Recent triage documentation
- ☐ Discharge summary
- ☐ Medication list
- ☐ CTO documents

☐ Other, please list:

Referrer Details

Referring clinical service:	
Referrer name:	**Designation:**
Contact details:	
Patient active with a mental health clinic? Y/ N	**Clinic**:
Treating Doctor:	**Case manager:**
Name of referrer: **Signature of referrer**	**Date:**