Armadale Kalamunda Group Service Directory

The Armadale Kalamunda Group is committed to enabling shared care planning with our local health and social care providers to assist in the management of complex patients with a chronic condition. This directory has been created to assist local health professionals in improving their management of these patients by increased access to the services available.

If you have any feedback, or think a service should be included, please email AHS.CareCoordination@health.wa.gov.au.

- **Aboriginal Health**
  - Derbarl Yerrigan Health Service
  - East Metropolitan Health Service (EMHS) Aboriginal Health Unit:
    - Moorditj Djena- Podiatry & Diabetes (Strong Feet)
    - Living Improvements for Everyone (LIFE) Program
    - I'm Moordidjabinj (Becoming Strong) Program
    - The Journey of Living with Diabetes Program
  - Arche Health - Wangen Murduin Integrated Team Care (ITC) Chronic Disease Program
  - Quitline Aboriginal Liaison Team (QLAT)

- **Allied Health**
  - Armadale Health Service – Community Rehabilitation
  - **Physiotherapy**
    - Armadale Health Service – Community Rehabilitation
    - Community Physiotherapy Service
    - Rehabilitation in the Home (RITH)
    - Silver Chain – Physiotherapy
    - Silver Chain – Hospital Discharge Support
  - **Occupational Therapy**
    - Armadale Health Service – Community Rehabilitation
    - Rehabilitation in the Home (RITH)
    - Silver Chain – Hospital Discharge Support (HDS)
  - **Dietetic services**
    - Armadale Health Service – Community Rehabilitation
    - Armadale Health Service – Nutrition and Dietetics Outpatients
    - 360 Health + Community – Dietetics
    - EMHS - Moorditj Djena Podiatry & Diabetes (Strong feet)
    - Derbarl Yerrigan Health Service – Dietician for Diabetes management
  - **Speech Therapy**
    - Armadale Health Service – Community Rehabilitation
    - Derbarl Yerrigan Health Service – Speech Therapy
  - **Exercise physiologists**
    - Strength for Life

        - 360 Health + Community – Exercise Physiology

- **Arthritis**
    - Arthritis and Osteoporosis WA
    - EMHS- Living Improvements for Everyone (LIFE) Program
- **Asthma**
    - Asthma Educational Individualised Sessions
    - EMHS - Living Improvements for Everyone (LIFE) Program

- **Carers**
    - Carers Australia WA
    - Dementia Australia
    - McCusker Nurse Service

- **Case Coordination**
    - Complex Needs Coordination Team (CoNeCT)
    - Arche Health - Wangen Murduin Integrated Team Care (ITC) Chronic Disease Program
    - Silver Chain – Primary Care at Home

- **Chronic Respiratory Conditions**
    - 360 Health + Community – Healthy Lifestyle Program (HLP)
    - Armadale Health Service – Pulmonary Rehabilitation
    - Lung Foundation
    - EMHS – Living Improvements For Everyone (LIFE) Program
    - Silver Chain – Respiratory Care
    - Derbarl Yerrigan Health Service – Respiratory Clinic

- **Chronic Cardiac Conditions**
    - 360 Health + Community – Healthy Lifestyle Program (HLP)
    - Armadale Health Service – Cardiac Rehabilitation
    - Curtin University Health and Wellness Clinic – Cardiac Exercise
    - Heart Foundation
    - EMHS - Living Improvements for Everyone (LIFE) Program
    - Derbarl Yerrigan Health Service – Cardiac Clinic
    - Arche Health - Wangen Murduin Integrated Team Care (ITC) Chronic Disease Program

- **Chronic Pain Management**
    - EMHS – Living Improvements For Everyone (LIFE) Program
    - Arche Health – Chronic Pain Management Service

- **Chronic Renal Disease**
    - Arche Health - Wangen Murduin Integrated Team Care (ITC) Chronic Disease Program
    - 360 Health + Community – Healthy Lifestyle Program (HLP)

- **Cognition and Memory**

- Dementia Australia
- McCusker Nurse Service

- **Continence assistance**
  - Armadale Health Service – Continence Clinic
  - Bladder and Bowel Health Australia
  - Continence Aids Payment Scheme (CAPS)
  - Continence Management and Advisory Service and Scheme (CMAS)

- **Diabetes management**
  - **Aboriginal specific programs**
    - EMHS - The Journey of Living with Diabetes Program
    - EMHS - Moorditj Djena- Podiatry & Diabetes (Strong feet)
    - EMHS – Living Improvements For Everyone (LIFE) Program
    - Derbarl Yerrigan Health Service (DYHS)
    - Arche Health - Wangen Murduin Integrated Team Care (ITC) Chronic Disease Program
  - **360 Health + Community**
    - Diabetes Education
    - Coordinated Endocrinology and Diabetes Service (CEDS)
    - 360 Health + Community – Healthy Lifestyle Program (HLP)
  - **Armadale Health Service – Adult Diabetes Service**
    - Diabetes Education
    - Multidisciplinary Diabetes Service
  - DESMOND
  - Curtin University Health and Wellness Clinic
  - Diabetes WA Information and Advice Line (DIAL)
  - Private Credentialed Diabetes Educators

- **Equipment needs**
  - Independent Living Centre

- **Exercise groups**
  - EMHS - I'm Moordidjabinj (Becoming Strong) Program
  - Local exercise groups

- **Hospital Avoidance and Discharge Support**
  - Silver Chain – Home Hospital
  - Silver Chain – Priority Response Assessment (PRA)
  - Silver Chain – Hospital Discharge Support (HDS)
  - Silver Chain – Primary Care at Home

- **Men's Shed**

- **Mental Health and Counselling**
  - PORTS
  - Derbarl Yerrigan Health Service- Counselling and Psychologist
  - Dementia Australia

- Carers WA

- **Neurological conditions**
  - Motor Neurone Disease WA
  - Multiple Sclerosis WA (MSWA)
  - Neurological Council of WA
  - Parkinson's WA

- **Palliative care**
  - Bethesda – MPaCCS
  - Silver Chain – Palliative Care

- **Podiatry**
  - EMHS - Moorditj Djena- Podiatry & Diabetes (Strong feet)
  - Derbarl Yerrigan Health Service
  - Armadale Health Service – Podiatry Outpatients

- **Residential Aged Care Services**
  - Silver Chain – Home Hospital
  - Silver Chain – Priority Response Assessment (PRA)
  - Bethesda Care

- **Seniors Clubs**

- **Services in the home/assessment for residential care**
  - Aged Care Assessment Team (ACAT)
  - Aged Care Guide
  - Home and Community Care Services (HACC)

- **Smoking Cessation and Support**
  - Quitline
  - Quitline Aboriginal Liaison Team

- **Support Groups**
  - Connect Groups

- **Sub-acute rehabilitation**
  - Armadale Health Service – Community Rehabilitation
  - Curtin University – Cockburn Clinic
  - Rehabilitation in the Home (RITH)
  - Silver Chain- Hospital Discharge Support (HDS)

- **Vision impairment**
  - VisAbility (formerly Association for the Blind)

- **Weight management**
  - Arche Health – Active Measures

ABORIGINAL HEALTH

Derbarl Yerrigan Health Service (DYHS)	
Service description	Derbarl Yerrigan Maddington offer a range of visiting programs that include; • Maternal & Child Health • Chronic Disease Management • Aboriginal Liaison Officer • Indigenous Outreach • Bringing them Home • Allied Health service. • Respiratory Clinic A range of other programs are also offered at alternate Derbarl Yerrigan clinics (East Perth, Midland and Mirabooka).
Relevant disciplines	• General Practitioners • Registered Nurses • Nurse Practitioner • Aboriginal Health Practitioner • Podiatrist • Respiratory Specialist
Eligibility criteria	• Aboriginal, Torres Strait Islander or Partner of an Aboriginal/TSI person (however not a requirement)
Referral method	Phone/Walk-in
Who can refer	Anyone – walk in service
Referral form link	N/A
Cost	All services are bulk billed to those who have a Medicare card
Location	Unit 1-2, Lot 5 Binley Place Maddington WA 6109 Derbal Yerrigan clinics are also located in East Perth, Midland, Mirrabooka. See the website for more details
Contact phone	Phone: (08) 9452 5333 Fax: (08) 9452 5344
Website	www.dyhs.org.au/

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ABORIGINAL HEALTHY LIFESTYLE PROGRAMS (EMHS): Moorditj Djena (Strong Feet)	
Service description	Moorditj Djena (Strong Feet) – Moorditj Djena is a podiatry and diabetes education outreach program for Aboriginal people within the Perth metropolitan area. Culturally appropriate podiatry and diabetes education for Aboriginal people is provided with a focus on prevention and management of foot complications and their risk factors such as diabetes, peripheral arterial disease, peripheral neuropathy and other chronic diseases. Services include: • Podiatry for assessment, treatment and education of all foot related concerns. This covers wound care, nail surgery, biomechanical assessment and orthotic provision. Education is also given regards choosing the correct footwear and how to look after your feet. • Aboriginal Health Workers for health interventions for prevention methods, health education, support and advocacy. • Dietitian to discuss healthy eating for diabetes and other chronic conditions, including ideas for shopping on a budget, cooking healthier meals and providing recipes. • Diabetes Educator to help clients self-manage their diabetes effectively and prevent complications.
Relevant conditions	• Diabetes • Vascular Disease, • Neuropathy • Obesity • Foot Deformity • Ulceration • Chronic foot problems
Eligibility criteria	• Aboriginal, Torres Strait Islander or Partner of an Aboriginal/ Torres Strait Islander person • ≥18 years old
Location	Multiple locations. Mobile vans that service the northern, southern and eastern metropolitan areas of Perth. Call for details.
Who can refer	Patients can self-refer. Health professionals can provide referrals/handovers for collateral information (GP, Allied Health Staff and Nurses).
Referral method	Walk-in appointments, or contact/book through phone, fax or email.
Contact Details	Phone: (08) 9278 9922 Fax: (08) 9250 1419 Email: moorditjdjena@health.wa.gov.au
Cost	Free
Website	https://emhs.health.wa.gov.au/Hospitals-and-Services/Aboriginal-Health/Moorditj-Djena
Resources	Program Brochure

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ABORIGINAL HEALTHY LIFESTYLE PROGRAMS (EMHS): Living Improvements for Everyone (LIFE) Program	
Service description	A course for Aboriginal people who are living with or caring for someone with a chronic condition. The aim of the LIFE course is to; • Give you the skills to self-manage your health • Understand your and/or others' illnesses • Deal with your feelings about your/others' sickness such as anger, sadness or fear • Learn how to cope with changes to your/others' life including new medicines or newly diagnosed illness
Relevant conditions	• Diabetes • Heart Condition • Kidney Problems • Asthma • Arthritis • Cancer or other long term illness
Eligibility criteria	• Aboriginal, Torres Strait Islander or Partner of an Aboriginal/TSI person • ≥18 years old
Who can refer	• Self- referral • GP/Health professional
Other information	The course runs weekly for 2.5 hours for 6 weeks
Cost	Free
Location	Multiple locations.
Website	http://www.emhs.health.wa.gov.au/Hospitals-and-Services/Aboriginal-Health/AHLP
Contact	Email: EMHS.HealthyLifeStylePrograms@health.wa.gov.au. Ph: 9224 3778 / 9224 3749
Resources	LIFE Program Brochure

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ABORIGINAL HEALTHY LIFESTYLE PROGRAMS (EMHS): I'm Moordidjabini (Becoming Strong) Program	
Service description	I'm Moordidjabinj (Becoming Strong) is a healthy lifestyle, nutritional education program designed to help community members change unhealthy lifestyles, improve fitness and make health food choices. The program includes exercise, education and cooking sessions
Relevant conditions	N/A
Website	http://www.emhs.health.wa.gov.au/Hospitals-and-Services/Aboriginal-Health/AHLP
Eligibility criteria	• Aboriginal, Torres Strait Islander or Partner of an Aboriginal/TSI person • ≥18 years old
Who can refer	• Self- referral • GP/Health professional
Referral method	N/A
Referral form link	N/A
Other information	The program is a 6-week program
Cost	Free
Location	Multiple locations
Contact phone	Email: EMHS.HealthyLifeStylePrograms@health.wa.gov.au. Ph: 9224 3778 / 9224 3749
Program Brochure	Program Brochure

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ABORIGINAL HEALTHY LIFESTYLE PROGRAMS (EMHS): The Journey of Living with Diabetes Program	
Relevant conditions	Type 2 Diabetes
Service description	This program is for Aboriginal people who have Type 2 diabetes. It was developed to help Aboriginal people to manage their diabetes. The program is run in groups and led by a trained Aboriginal health professional. Discussion and sharing stories are used to help you learn about your diabetes and how you can make changes to best look after your health
Eligibility criteria	• Aboriginal, Torres Strait Islander or Partner of an Aboriginal/TSI person • ≥18 years old
Who can refer	• GP/Health professional • Self-referral (however requires doctors clearance)
Referral method	N/A
Referral form link	N/A
Other information	The program is run over 6-8 sessions Programs are held locally and transport can be arranged. Families are welcome.
Cost	Free
Location	Multiple locations
Website	http://www.emhs.health.wa.gov.au/Hospitals-and-Services/Aboriginal-Health/AHLP
Contact phone	Email: EMHS.HealthyLifeStylePrograms@health.wa.gov.au. Ph: 9224 1981
Program Brochure	Program Brochure

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ARCHE HEALTH: Wangen Murduin Integrated Team Care (ITC) Chronic Disease Program	
Service description	The Arche Health Wangen Murduin Integrated Team Care (ITC) program aims to improve the health of Aboriginal and Torres Strait Islander people who suffer from a chronic disease. The program is delivered by a team of indigenous Health Project Officers, Indigenous Outreach Workers and Care Coordinators. The service aims to provide the following assistance; • Work with your doctor to support you with your health care plans • Visit you at home • Assist you to access services • Include appropriate clinical care • Arrange appointments when required • Ensure regular GP visits • Deliver medication and assist with a medication review • Involve you in the decisions about your health care • Advocate and assist with any barriers • Follow up with your health care schedule • Assist you with transport to medical appointments
Eligibility criteria	• Aboriginal, Torres Strait Islander • One or more of the following chronic conditions; diabetes, heart disease, renal failure, respiratory conditions or cancer • Care plan completed by GP
Who can refer	• Self referral • GP • Other health professionals
Referral method	Please complete referral form and consent form and either fax to 9458 8733 or email to aht@archehealth.com.au
Referral form link	Referral form Consent form
Website	http://www.archehealth.com.au/ours-services/aboriginal-health/
Cost	Free
Location	N/A
Contact phone	Phone: (08) 9458 0505 Fax: (08) 9458 8733
Program Brochure	Wangen Murdiun ITC Brochure

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Quitline Aboriginal Liaison Team (QALT)	
Service description	The QALT Project Officers focus on promoting the Quitline and providing information about the Quitline service to primary health care services who work with Aboriginal and Torres Strait Islander people in Western Australia (WA) to support and promote Quitline referrals and overall reducing the prevalence and incidence of smoking rates within WA. Our primary focus is to support the non-Tackling Indigenous Smoking (TIS) recipients in the South West & Great Southern regions although we do provide support across state – wide of Western Australia how are we doing this? • Continually provide support to health services who engage with Aboriginal and Torres Strait Islander people to Quitline • Support the regional & remote TIS teams across WA • Working in collaboration with key stakeholders i.e. Australian Council Of Smoking Health (ACOSH) , Cancer Council Western Australia (CCWA), Cancer Council South Australia (CCSA) • Attend metro, regional and remote community events promoting the Quitline • Distribution of QALT resources to local AMS's and hospitals within WA • Creating & redeveloping new culturally safe/relevant resources • Promote, organise and support Quitskills three day nationally recognised training on smoking cessation • Deliver a component on Day 3 of the Quitskills training – promoting the Quitline • Provide 1 day free Brief Intervention Training session
Who can refer	• The patient can self-refer by calling 13 78 48 • Allied health, nursing and medical professionals can refer online or via email.
Referral method	Email (using referral form) Through website (through online referral form)
Referral form link	https://www.cancersa.org.au/health-professionals/referrals/
Other information	• Opening Hours: Monday – Friday 8am to 8pm & Saturday 12:30pm to 3:30pm • Once referral is received they will contact you within 24 hours • The cost of the call is the same as a standard phone call, if needed they will call you back to save money • Aboriginal Counsellors are available • Use of interpreter service available if required • Provide support to individuals, families or groups wanting to cut down or quit • Discuss Nicotine Replacement therapy options and availability • Able to link people to services within local areas • Service available for up to 3 months, can be longer if the client needs.
Website	https://www.ahcwa.org.au/qalt
Cost	FREE
Contact	Phone: (08) 9227 1631 Email: qalt@ahcwa.org

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ALLIED HEALTH

Armadale Health Service: Community Rehabilitation	
Relevant disciplines	Allied health, medical and nursing
Service description	Community Rehabilitation delivers outpatient subacute care to people living in the community. This multidisciplinary service provides adult clients with a comprehensive assessment and rehabilitation service to regain or retain certain physical or cognitive function. The Community Rehabilitation team consists of: • Clinical Psychologist • Dietitian • Falls specialist coordinators • Geriatricians • Nurse • Occupational Therapist • Physiotherapist • Rehabilitation physician • Social Worker • Speech Pathologist • Therapy Assistant
Website	Community rehabilitation (health.wa.gov.au)
Eligibility criteria	• aged 18+ • reside in the Armadale Health Service catchment • be medically stable and safe for hospital discharge • has a GP willing to provide medical support (clients without a usual GP will be assisted to access GP services and geriatrician/rehabilitation physician support will be provided if indicated) • willing to engage in treatment
Who can refer	• GP • hospital staff
Referral method	Electronic-Referrals Referrals to see a community rehabilitation doctor must be sent through to the Central Referral System. All other referrals – Fax: 9391 2262.

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ALLIED HEALTH: Physiotherapy

Armadale Health Service: Community Rehabilitation	
Relevant disciplines	Allied health, medical and nursing
Service description	Community Rehabilitation delivers outpatient subacute care to people living in the community. This multidisciplinary service provides adult clients with a comprehensive assessment and rehabilitation service to regain or retain certain physical or cognitive function. The Community Rehabilitation team consists of: • Clinical Psychologist • Dietitian • Falls specialist coordinators • Geriatricians • Nurse • Occupational Therapist • Physiotherapist • Rehabilitation physician • Social Worker • Speech Pathologist • Therapy Assistant
Website	Community rehabilitation (health.wa.gov.au)
Eligibility criteria	• aged 18+ • reside in the Armadale Health Service catchment • be medically stable and safe for hospital discharge • has a GP willing to provide medical support (clients without a usual GP will be assisted to access GP services and geriatrician/rehabilitation physician support will be provided if indicated) • willing to engage in treatment
Who can refer	• GP • hospital staff
Referral method	Electronic-Referrals Referrals to see a community rehabilitation doctor must be sent through to the Central Referral System. All other referrals – Fax: 9391 2262.

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Community Physiotherapy Services (CPS)	
Relevant discipline	Physiotherapist
Service description	Out of hospital discharge option for patients requiring further physiotherapy intervention following an episode of Inpatient, RITH, or Outpatient care. CPS is staffed by Senior Physiotherapists and delivers group based physiotherapy rehabilitation in the community both on land and in water at local community pools and recreation centres. Programs are designed for people with conditions affecting their health or mobility, including respiratory, cardiovascular, neurological and musculoskeletal conditions. Rehabilitation programs are also provided for patients with balance problems; frailty and general deconditioning; and those recovering from join replacement surgery or traumatic injury.
Website	CPS (only accessible to hospital staff)
Eligibility criteria	Refer to website for criteria
Who can refer	Hospital staff only (GP and Private referrals cannot be accepted).
Referral method	Fax: 6152 4211 Email: SMHS.CPS@health.wa.gov.au
Referral form link	N/A
Other information	Please provide a printout of the patients discharge summary where available. Due to the use of Community Venues there are restrictions on acceptance of referrals for bariatric patients. Please phone the referral office to discuss referral of patients >120kg.
Cost	No fee; however there may be a small cost associated with entry at some pools.
Location	Community venues
Contact phone	6452 0816

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Rehabilitation In The Home (RITH)	
Service description	Rehabilitation in the Home (RITH) provides short to medium term hospital substitution allied health therapy for patients at home. The service aims to facilitate early supported discharge from hospitals or avoidance of hospital admission for patients.
Relevant Disciplines	• Physiotherapy • Occupational Therapy • Speech Pathology • Dietetics
Eligibility criteria	To be eligible for RITH, the patient must: • require allied health services which would require hospitalisation and cannot be provided in an outpatient clinic or community setting • be medically stable • have adequate home support • have an accessible and safe home environment • be able to actively participate in goal orientated rehab program • consent to allied health service at home • live in the Perth metropolitan area Patients are NOT eligible to receive the RITH service if they: • receive, or are able to receive, or should receive therapy in an outpatient setting • require one-off visits for equipment or provision of home-based services • are referred to Silver Chain Personal Enablement Program • may place staff at an unreasonable risk of harm • reside in a prison • are referred directly from a GP • reside in a residential care facility/require maintenance therapy
Who can refer	Hospital allied health staff.
Referral method	**Referral Process** Contact the relevant RITH site's Intake Therapist / Coordinator to discuss the referral BEFORE the patient is discharged from the hospital. See contact details. 1. Complete the RITH referral form 2. Ensure RITH consent section is signed by the patient, including the separate RITH Contract when indicated. 3. Ensure the Risk Identification section is completed. 4. Send the completed forms and all other relevant handover information to RITH via fax / email. Refer to contact details. **After Hours Referrals** RITH accepts referrals to from 8am to 9pm on weekdays and 8:30am to 5pm on weekends. To make a referral after hours; 1. Contact the RITH on call referral service via RPH Switchboard at 9224 2244. 2. Discuss the referral with the on call RITH staff. 3. If the referral is accepted, complete RITH referral and all other relevant forms/handover indicated (as above) 4. Send the completed documentation to the relevant RITH

	sites via fax / email. Refer to contact details.
Referral form link	Rehabilitation in the Home/Referral Form (only accessible to hospital staff)
Cost	Free
Location	Service is provided in the client's home.
Contact phone	6477 5151 After hours – 9224 2244

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Silver Chain – Physiotherapy	
Service description	Physiotherapist visits patient in their home to assess their mobility, balance, strength and endurance and design an individualised program that will assist the patient to remain safe and mobile in their home and community. Short term program for patients who find it difficult to access physiotherapy services outside their home.
Website	Silver Chain – Physiotherapy
Referral method	Requires a referral from the Regional Assessment Service to access service: 1300 785 415 Complete referral form – Fax: 6383 2911 Telephone referrals: 9242 0347
Cost	Free of charge or contribution towards the cost.
Contact phone	9242 0242

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Silver Chain- Hospital Discharge Support	
Service description	Hospital Discharge Support is rapid response service which provides support to you in the community. It will help you recover from a recent illness or surgery. Our allied health team will assess you in your home and design a short-term program around your own goals. The length of time you will spend in the program depends on your individual needs. Our aim is to get you back on your feet and help you avoid a return to hospital. HDS is an Allied Health led, evidence based, reablement service for clients coming out of hospital. HDS aims to support the successful discharge of clients and prevent unnecessary readmission. HDS includes setting up the home environment successfully for the client, falls prevention and reablement towards activities the person was doing prior to their hospital stay. The program goals, types of supports, services and frequency of visits are determined by the Silver Chain Allied Health Professional in conjunction with the client following assessment. HDS Services are delivered between 7am-5pm, Monday – Friday.
Relevant Disciplines	• Physiotherapy • Occupational Therapy
Eligibility criteria	Patient's must: • Be in hospital at the time of the referral • Be medically stable • Reside in an area where Hospital Discharge Support is available. • Patient must have a functional need which requires Personal Care as part of the service (Previous HACC eligibility will be applied) Not Eligible: • Private patients in private hospitals • Patients with NDIS funding • Patients in receipt of a Home Care Package (they may be able to receive an HDS service funded through their package and should check with their provider if this is possible), or they may be able to access Allied Health Reablement services via CHSP • Clients awaiting a Home Care Package (they may be able to access Allied Health Restorative Care Services through CHSP). They can be referred to My Aged Care. • HDS is available to eligible clients for up to 6 weeks. HDS clients may be referred to other services where their needs exceed a 6-week service.
Who can refer	• Medical • Allied Health • Nursing
Website	Silver Chain – Hospital Discharge Support
Referral method	Weekdays: between 8:30am and 4:30pmreferrals can be made to Allied Health Liaison via phone (9242 0347). Be prepared to answer questions relating to the patient by way of a phone

	screening. After hours: between 4:30pm and 11pm weekdays, weekends and public holidays referrals can be made to ALN's from ED or equivalent only via phone (9242 0347). A phone screening tool is used.
Cost	FREE
Contact phone	Allied Health Liaison 9242 0347

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ALLIED HEALTH: Occupational Therapy

Armadale Health Service: Community Rehabilitation	
Relevant disciplines	Allied health, medical and nursing
Service description	Community Rehabilitation delivers outpatient subacute care to people living in the community. This multidisciplinary service provides adult clients with a comprehensive assessment and rehabilitation service to regain or retain certain physical or cognitive function. The Community Rehabilitation team consists of: • Clinical Psychologist • Dietitian • Falls specialist coordinators • Geriatricians • Nurse • Occupational Therapist • Physiotherapist • Rehabilitation physician • Social Worker • Speech Pathologist • Therapy Assistant
Website	Community rehabilitation (health.wa.gov.au)
Eligibility criteria	• aged 18+ • reside in the Armadale Health Service catchment • be medically stable and safe for hospital discharge • has a GP willing to provide medical support (clients without a usual GP will be assisted to access GP services and geriatrician/rehabilitation physician support will be provided if indicated) • willing to engage in treatment
Who can refer	• GP • hospital staff
Referral method	Electronic-Referrals Referrals to see a community rehabilitation doctor must be sent through to the Central Referral System. All other referrals – Fax: 9391 2262.

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Rehabilitation In The Home (RITH)	
Service description	Rehabilitation in the Home (RITH) provides short to medium term hospital substitution allied health therapy for patients at home. The service aims to facilitate early supported discharge from hospitals or avoidance of hospital admission for patients.
Relevant Disciplines	• Physiotherapy • Occupational Therapy • Speech Pathology • Dietetics
Eligibility criteria	To be eligible for RITH, the patient must: • require allied health services which would require hospitalisation and cannot be provided in an outpatient clinic or community setting • be medically stable • have adequate home support • have an accessible and safe home environment • be able to actively participate in goal orientated rehab program • consent to allied health service at home • live in the Perth metropolitan area Patients are NOT eligible to receive the RITH service if they: • receive, or are able to receive, or should receive therapy in an outpatient setting • require one-off visits for equipment or provision of home-based services • are referred to Silver Chain Personal Enablement Program (PEP) • may place staff at an unreasonable risk of harm • reside in a prison • are referred directly from a GP • reside in a residential care facility/require maintenance therapy
Who can refer	Hospital allied health staff.
Referral method	**Referral Process** Contact the relevant RITH site's Intake Therapist / Coordinator to discuss the referral BEFORE the patient is discharged from the hospital. See contact details. 5. Complete the RITH referral form 6. Ensure RITH consent section is signed by the patient, including the separate RITH Contract when indicated. 7. Ensure the Risk Identification section is completed. 8. Send the completed forms and all other relevant handover information to RITH via fax / email. Refer to contact details. **After Hours Referrals** RITH accepts referrals to from 8am to 9pm on weekdays and 8:30am to 5pm on weekends. To make a referral after hours; 5. Contact the RITH on call referral service via RPH Switchboard at 9224 2244. 6. Discuss the referral with the on call RITH staff. 7. If the referral is accepted, complete RITH referral and all other relevant forms/handover indicated (as above) 8. Send the completed documentation to the relevant RITH

	sites via fax / email. Refer to contact details.
Referral form link	Rehabilitation in the Home/Referral Form (only accessible to hospital staff)
Cost	Free
Location	Service is provided in the client's home.
Contact phone	6477 5151 After hours – 9224 2244

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Silver Chain - Hospital Discharge Support (HDS)	
Service description	Hospital Discharge Support is rapid response service which provides support to you in the community. It will help you recover from a recent illness or surgery. Our allied health team will assess you in your home and design a short-term program around your own goals. The length of time you will spend in the program depends on your individual needs. Our aim is to get you back on your feet and help you avoid a return to hospital. HDS is an Allied Health led, evidence based, reablement service for clients coming out of hospital. HDS aims to support the successful discharge of clients and prevent unnecessary readmission. HDS includes setting up the home environment successfully for the client, falls prevention and reablement towards activities the person was doing prior to their hospital stay. The program goals, types of supports, services and frequency of visits are determined by the Silver Chain Allied Health Professional in conjunction with the client following assessment. HDS Services are delivered between 7am-5pm, Monday to Friday.
Relevant Disciplines	• Physiotherapy • Occupational Therapy
Eligibility criteria	Patient's must: • Be in hospital at the time of the referral • Be medically stable • Reside in an area where Hospital Discharge Support is available. • Patient must have a functional need which requires Personal Care as part of the service (Previous HACC eligibility will be applied) Not Eligible: • Private patients in private hospitals • Patients with NDIS funding • Patients in receipt of a Home Care Package (they may be able to receive an HDS service funded through their package and should check with their provider if this is possible), or they may be able to access Allied Health Reablement services via CHSP • Clients awaiting a Home Care Package (they may be able to access Allied Health Restorative Care Services through CHSP). They can be referred to My Aged Care. • HDS is available to eligible clients for up to 6 weeks. HDS clients may be referred to other services where their needs exceed a 6-week service.
Who can refer	• Medical • Allied Health • Nursing
Website	Silver Chain – Hospital Discharge Support
Referral method	Weekdays: between 8:30am and 4:30pm referrals can be made to Allied Health Liaison via phone (9242 0347). Be prepared to

	answer questions relating to the patient by way of a phone screening. After hours: between 4:30pm and 11pm weekdays, weekends and public holidays referrals can be made to ALN's from ED or equivalent only via phone (9242 0347). A phone screening tool is used.
Cost	FREE
Contact phone	Allied Health Liaison 9242 0347

ALLIED HEALTH: Dietetics

Armadale Health Service: Community Rehabilitation	
Relevant disciplines	Allied health, medical and nursing
Service description	Community Rehabilitation delivers outpatient subacute care to people living in the community. This multidisciplinary service provides adult clients with a comprehensive assessment and rehabilitation service to regain or retain certain physical or cognitive function. The Community Rehabilitation team consists of: • Clinical Psychologist • Dietitian • Falls specialist coordinators • Geriatricians • Nurse • Occupational Therapist • Physiotherapist • Rehabilitation physician • Social Worker • Speech Pathologist • Therapy Assistant
Website	Community rehabilitation (health.wa.gov.au)
Eligibility criteria	• aged 18+ • reside in the Armadale Health Service catchment • be medically stable and safe for hospital discharge • has a GP willing to provide medical support (clients without a usual GP will be assisted to access GP services and geriatrician/rehabilitation physician support will be provided if indicated) • willing to engage in treatment
Who can refer	• GP • hospital staff
Referral method	Electronic-Referrals Referrals to see a community rehabilitation doctor must be sent through to the Central Referral System. All other referrals – Fax: 9391 2262.

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AHS Nutrition and Dietetic Outpatients	
Relevant disciplines	Dietitian
Service description	This includes the assessment of an individual's nutritional needs, education and support required to assist people to manage their health and medical conditions.
Website	Armadale Health Service – Nutrition and Dietetics
Eligibility criteria	General dietetic outpatient services are provided for post discharge follow up care ONLY.
Who can refer	• allied health • GP • nurse
Referral method	Please refer to criteria to determine which service to refer to. Referral forms will differ for each service.
Cost	Free
Location	Armadale Community Health and Development Centre 3056 Albany Highway, Armadale
Contact phone	9391 2361

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360 Health + Community Dietetics	
Relevant disciplines	Dietitian
Service description	Dietitians can provide the information needed for weight loss, eating healthily and improving quality of life. A dietitian can help by: • building a diet plan to help a patient lose weight and function at their optimum • outlining a program for cooking healthy food and healthy snacks • offering personalised nutrition advice • giving practical tips for healthy shopping and portion control.
Website	360 Health + Community/Dietetics
Who can refer	• allied health referral • GP referral • self-referral
Referral method	Fax completed referral form to: 9527 1193 If patient is self-referring contact 1300 706 922 to speak to the team.
Referral form link	360 Health + Community/Allied Health referral form
Other information	Referral not needed. Anyone can access dietetic services.
Cost	Variable. Subsidies are available for eligible participants, and rebates are available from most major health funds.
Location	5/51A Church Ave, Armadale 6112 (available at multiple locations across Perth metro area)
Contact phone	360 Health Centre Armadale – 1300 706 922

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ABORIGINAL HEALTHY LIFESTYLE PROGRAMS (EMHS): Moorditj Djena (Strong Feet)	
Service description	Moorditj Djena (Strong Feet) – Moorditj Djena is a podiatry and diabetes education outreach program for Aboriginal people within the Perth metropolitan area. Culturally appropriate podiatry and diabetes education for Aboriginal people is provided with a focus on prevention and management of foot complications and their risk factors such as diabetes, peripheral arterial disease, peripheral neuropathy and other chronic diseases. Services include: • Podiatry for assessment, treatment and education of all foot related concerns. This covers wound care, nail surgery, biomechanical assessment and orthotic provision. Education is also given regards choosing the correct footwear and how to look after your feet. • Aboriginal Health Workers for health interventions for prevention methods, health education, support and advocacy. • Dietitian to discuss healthy eating for diabetes and other chronic conditions, including ideas for shopping on a budget, cooking healthier meals and providing recipes. • Diabetes Educator to help clients self-manage their diabetes effectively and prevent complications.
Relevant conditions	• Diabetes • Vascular Disease, • Neuropathy • Obesity • Foot Deformity • Ulceration • Chronic foot problems
Eligibility criteria	• Aboriginal, Torres Strait Islander or Partner of an Aboriginal/ Torres Strait Islander person • ≥18 years old
Location	Multiple locations. Mobile vans that service the northern, southern and eastern metropolitan areas of Perth. Call for details.
Who can refer	Patients can self-refer. Health professionals can provide referrals/handovers for collateral information (GP, Allied Health Staff and Nurses).
Referral method	Walk-in appointments, or contact/book through phone, fax or email.
Contact Details	Phone: (08) 9278 9922 Fax: (08) 9250 1419 Email: moorditjdjena@health.wa.gov.au
Cost	Free
Website	https://emhs.health.wa.gov.au/Hospitals-and-Services/Aboriginal-Health/Moorditj-Djena
Resources	Program Brochure

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Derbarl Yerrigan Health Service (DYHS)	
Service description	Derbarl Yerrigan Maddington offer a range of visiting programs that include; • Maternal & Child Health • Chronic Disease Management • Aboriginal Liaison Officer • Indigenous Outreach • Bringing them Home • Allied Health service. • Respiratory Clinic A range of other programs are also offered at alternate Derbarl Yerrigan clinics (East Perth, Midland and Mirabooka).
Relevant disciplines	• General Practitioners • Registered Nurses • Nurse Practitioner • Aboriginal Health Practitioner • Podiatrist • Respiratory Specialist
Eligibility criteria	• Aboriginal, Torres Strait Islander or Partner of an Aboriginal/TSI person (however not a requirement)
Referral method	Phone/Walk-in
Who can refer	Anyone – walk in service
Cost	All services are bulk billed to those who have a Medicare card
Location	Unit 1-2, Lot 5 Binley Place Maddington WA 6109
Contact phone	Phone: (08) 9452 5333 Fax: (08) 9452 5344
Website	www.dyhs.org.au/

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ALLIED HEALTH: Speech Pathology

Armadale Health Service: Community Rehabilitation	
Relevant disciplines	Allied health, medical and nursing
Service description	Community Rehabilitation delivers outpatient subacute care to people living in the community. This multidisciplinary service provides adult clients with a comprehensive assessment and rehabilitation service to regain or retain certain physical or cognitive function. The Community Rehabilitation team consists of: • Clinical Psychologist • Dietitian • Falls specialist coordinators • Geriatricians • Nurse • Occupational Therapist • Physiotherapist • Rehabilitation physician • Social Worker • Speech Pathologist • Therapy Assistant
Website	Community rehabilitation (health.wa.gov.au)
Eligibility criteria	• aged 18+ • reside in the Armadale Health Service catchment • be medically stable and safe for hospital discharge • has a GP willing to provide medical support (clients without a usual GP will be assisted to access GP services and geriatrician/rehabilitation physician support will be provided if indicated) • willing to engage in treatment
Who can refer	• GP • hospital staff
Referral method	Electronic-Referrals Referrals to see a community rehabilitation doctor must be sent through to the Central Referral System. All other referrals – Fax: 9391 2262.

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Derbarl Yerrigan Health Service (DYHS)	
Service description	Derbarl Yerrigan Maddington offer a range of visiting programs that include; • Maternal & Child Health • Chronic Disease Management • Aboriginal Liaison Officer • Indigenous Outreach • Bringing them Home • Allied Health service. • Respiratory Clinic A range of other programs are also offered at alternate Derbarl Yerrigan clinics (East Perth, Midland and Mirabooka).
Relevant disciplines	• General Practitioners • Registered Nurses • Nurse Practitioner • Aboriginal Health Practitioner • Podiatrist • Respiratory Specialist
Eligibility criteria	• Aboriginal, Torres Strait Islander or Partner of an Aboriginal/TSI person (however not a requirement)
Referral method	Phone/Walk-in
Who can refer	Anyone – walk in service
Website	www.dyhs.org.au/
Cost	All services are bulk billed to those who have a Medicare card
Location	Unit 1-2, Lot 5 Binley Place Maddington WA 6109
Contact phone	Phone: (08) 9452 5333 Fax: (08) 9452 5344

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ALLIED HEALTH: Exercise Physiologists

Strength for Life	
Service description	Evidence based strength and exercise program for people over 50yrs. Aims to reduce falls and improve quality of life. **Tier One** providers of the program are exercise physiologists or physiotherapists who have the skills and experience to deal with those participants who have chronic conditions or are in need of rehabilitation services. **Tier Two** providers are professional fitness instructors who have completed extra Living Longer Living Stronger training and are equipped to deal with those participants with minor health conditions.
Website	Strength for Life – COTA WA
Eligibility criteria	N/A
Who can refer	• GP
Referral method	See instructions on website below
Referral form link	Medical Referrals – COTA WA
Cost	Cost varies for each location. See website for details
Location	Multiple locations available across Perth. See website for details
Contact phone	9472 0104

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360 Health + Community Exercise Physiology	
Relevant disciplines	Exercise physiologist
Service description	An exercise physiologist works one-on-one with patients to develop personalised exercise plans and exercise rehabilitation plans based on their goals, health, and injury history. This is done through in depth exercise assessments such as aerobic, strength, endurance, range of motion, manual muscle testing, posture, gait and functional testing.
Website	https://www.360.org.au/
Eligibility criteria	N/A
Who can refer	• allied health referral • GP referral • self-referral
Referral method	Fax completed referral form to: 9527 1193 If patient is self-referring contact 1300 706 922 to speak to the team
Referral form link	360 Health + Community/Allied Health Referral
Other information	Referral not needed. Anyone can access exercise physiology sessions.
Cost	Variable. Subsidies are available for eligible participants, and rebates are available from most major health funds.
Location	5/51A Church Ave, Armadale 6112 (available at multiple locations across Perth metro area)
Contact phone	360 Health Centre Armadale – 1300 706 922

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ARTHRITIS

Arthritis and Osteoporosis WA	
Relevant conditions	Arthritis and Osteoporosis.
Service description	Provides the following: • self-management courses • exercise classes • telephone advisory service • social lines – regular contact with an AOWA volunteer.
Website	Arthritis & Osteoporosis WA
Eligibility criteria	N/A
Who can refer	Self-enrolment.
Referral method	Information or enrolment: Phone: 9388 2199 Email: general@arthritiswa.org.au
Contact phone	9388 2199
Other information	See website for specific information regarding support groups, exercise classes, and telephone services.
Cost	Free.
Location	17 Lemnos Street, Shenton Park, WA 6008

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ABORIGINAL HEALTHY LIFESTYLE PROGRAMS (EMHS): Living Improvements for Everyone (LIFE) Program	
Service description	A course for Aboriginal people who are living with or caring for someone with a chronic condition. The aim of the LIFE course is to; • Give you the skills to self-manage your health • Understand your and/or others' illnesses • Deal with your feelings about your/others' sickness such as anger, sadness or fear • Learn how to cope with changes to your/others' life including new medicines or newly diagnosed illness
Relevant conditions	• Diabetes • Heart Condition • Kidney Problems • Asthma • Arthritis • Cancer or other long term illness
Eligibility criteria	• Aboriginal, Torres Strait Islander or Partner of an Aboriginal/TSI person • ≥18 years old
Who can refer	• Self- referral • GP/Health professional
Other information	The course runs weekly for 2.5 hours for 6 weeks
Cost	Free
Location	Multiple locations.
Website	https://www.emhs.health.wa.gov.au/Hospitals-and-Services/Aboriginal-Health/AHLP
Contact	Email: EMHS.HealthyLifeStylePrograms@health.wa.gov.au. Ph: 9224 3778 / 9224 3749
Resources	LIFE Program Brochure

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ASTHMA

Asthma Educational Individualised Sessions	
Relevant conditions	Clients with asthma.
Service description	Our asthma educators will provide support and up-to-date information on asthma during a one-on-one or small group session. When discussing your asthma the following topics will be covered: • what asthma is • asthma control score • signs and symptoms of asthma • assessing asthma severity • how your medicines help you to better manage your asthma • checking your medication device technique • what a trigger is and how to manage/avoid these • understanding your asthma action plan Asthma First Aid
Who can refer	• self-referral • any health professional.
Referral method	Complete online form on website and an asthma educator will contact you with an appointment date.
Referral form link	https://asthmawa.org.au/service/health-professional/
Website	https://asthmawa.org.au/
Cost	Free
Location	Armadale Community & Development Centre 3056 Albany Hwy, Armadale WA 6112
Contact phone	9289 3600

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ABORIGINAL HEALTHY LIFESTYLE PROGRAMS (EMHS): Living Improvements for Everyone (LIFE) Program	
Service description	A course for Aboriginal people who are living with or caring for someone with a chronic condition. The aim of the LIFE course is to; • Give you the skills to self-manage your health • Understand your and/or others' illnesses • Deal with your feelings about your/others' sickness such as anger, sadness or fear • Learn how to cope with changes to your/others' life including new medicines or newly diagnosed illness
Relevant conditions	• Diabetes • Heart Condition • Kidney Problems • Asthma • Arthritis • Cancer or other long term illness
Eligibility criteria	• Aboriginal, Torres Strait Islander or Partner of an Aboriginal/TSI person • ≥18 years old
Who can refer	• Self- referral • GP/Health professional
Other information	The course runs weekly for 2.5 hours for 6 weeks
Cost	Free
Location	Multiple locations.
Website	www.emhs.health.wa.gov.au/Hospitals-and-Services/Aboriginal-Health/AHLP
Contact	Email: EMHS.HealthyLifeStylePrograms@health.wa.gov.au. Ph: 9224 3778 / 9224 3749
Resources	LIFE Program Brochure

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CARERS

Carers Australia WA	
Service description	Provide the following services for anyone who is a carer for someone else, including young carers: • counselling • information and advice • education and training • Carer Wellness at Home Program • social support • Prepare to Care Hospital Program • Carer Representation Program • Young Carer's Program • better start for children with disability • working carers support • carers retreat
Website	Carers WA
Eligibility criteria	N/A
Who can refer	• self-referral/enrolment - health professionals can provide carer with Carers WA information pack • allied health • GP.
Referral method	Carers can self-refer by calling the number listed below otherwise health professionals can complete the form provided in the link below.
Referral form link	https://wa.healthpathways.org.au/357366.htm
Other information	Patient handouts are available to download at Digital Resources for Carers in Western Australia | Carers WA
Cost	Variable depending on program.
Location	182 Lord Street, Perth WA 6000
Contact phone	General Enquires: 1300 227 377 Carers Counselling Line: 1800 007 332 Advisory Line: 1300 227 377

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Dementia Australia	
Relevant conditions	Alzheimer's disease
Service description	Provides specialist services to people with dementia and their families/carers, including: • National Dementia Helpline • Carer's Support Groups • Carer Support and Information Program • Dementia Enavling Environments Project • Counselling • Education Workshops • Behaviour Management Advisory Service • Respite Options • Art Programmes.
Website	Dementia Australia
Who can refer	Self-referral
Referral method	Phone: 9388 2800
Cost	Most services are free. Some may require a payment depending on the patient.
Location	55 Walters Drive, Osborne Park 6017
Contact phone	Osborne Park Head Office: 9388 2800 Dementia Helpline: 1800 100 500

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McCusker Nurse Service	
Service description	The McCusker Nurse Service provides free support for the carers of those living with dementia The McCusker Nurse is a dementia expert, who can help carers and families understand the condition and navigate the support options available to them at any stage in the illness. Your McCusker Nurse walks alongside you, to improve wellbeing and quality of life for both you and the person living with dementia. By accessing suitable support, the person with dementia is often able to live in their own home for longer with services delivered to them, only moving into residential care when the time is right.
Website	McCusker Nurse
Eligibility criteria	Client must be living within specific areas north and south of the Swan River in Perth. Call the number listed below to check eligibility
Who can refer	• Self-referral/ family • Health professional
Referral method	Call or email McCusker Nurse South Ph: 9424 6697 Mobile: 0437 110 928 Email: McCuskerNurseSouth@amanaliving.com.au McCusker Nurse North Ph: 9424 6396 Mobile: 0417 519 253 Email: McCuskerNurseNorth@amanaliving.com.au
Location	McCusker Nurse South Club Lefroy, 22 Lefroy Rd Bull Creek WA 6149 McCusker Nurse North 541 Hay street Subiaco WA 6008

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CASE COORDINATION

Complex Needs Coordination Team (CoNeCT)	
Service description	Care Coordination service for patients who present frequently to ED or have long stays or those at risk of this. The service aims to link individuals to ongoing supports and provide education to assist patients in managing their care at home and avoiding preventable readmissions to hospital.
Website	CoNeCT at AHS
Eligibility criteria	• 3 or more ED presentations in previous 12 months **or** • long stay over 10 days **or** • risk of readmissions **and** • chronic disease • patient's consent to service.
Who can refer	• GP (see other information) • hospital staff.
Referral method	To discuss your referral, please call: 0404 890 092
Referral form link	N/A
Other information	CoNeCT will also visit inpatients known to the service. Patients cannot use CoNeCT if they pose a safety risk to staff for home visiting. Referral to CoNeCT by GPs will be considered if the patient has a recent history of frequent ED presentations which could have been avoided through care coordination intervention in the community.
Cost	Free.
Location	Service delivered in patient's home.
Contact phone	0404 890 092

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Arche Health Wangen Murduin Integrated Team Care (ITC) Chronic Disease Program	
Service description	The Arche Health Wangen Murduin Integrated Team Care (ITC) program aims to improve the health of Aboriginal and Torres Strait Islander people who suffer from a chronic disease. The program is delivered by a team of indigenous Health Project Officers, Indigenous Outreach Workers and Care Coordinators. The service aims to provide the following assistance; • Work with your doctor to support you with your health care plans • Visit you at home • Assist you to access services • Include appropriate clinical care • Arrange appointments when required • Ensure regular GP visits • Deliver medication and assist with a medication review • Involve you in the decisions about your health care • Advocate and assist with any barriers • Follow up with your health care schedule • Assist you with transport to medical appointments
Eligibility criteria	• Aboriginal, Torres Strait Islander • One or more of the following chronic conditions; diabetes, heart disease, renal failure, respiratory conditions or cancer • Care plan completed by GP
Who can refer	• Self referral • GP • Other health professionals
Referral method	Please complete referral form and consent form and either fax to 9458 8733 or email to aht@archehealth.com.au
Cost	Free
Contact phone	Phone: (08) 9458 0505 Fax: (08) 9458 8733

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Silver Chain – Primary Care at Home	
Service description	PCAH is designed to reconnect vulnerable and disadvantaged people in the Perth metro area with the primary health services they need. We can help your clients manage their health concerns, alleviating a major source of stress for them and their support network. If you have clients who've have had difficulties connecting with GPs, understanding health matters or are simply disconnected from the health care system, we can help. Our Nurse Practitioners create a trusted bridge between clients and health professionals, including medication management and referrals as well as supporting applications for additional services like transportation and help around the home. Wait times are minimal for the program. We will contact you or your client within 7 days.
Website	https://www.silverchain.org.au/wa/referrers/refer-to-primary-care-at-home/
Eligibility criteria	Referral requirements: 1. Live in metropolitan Perth (Two Rocks to Pinjarra) 2. Have health concerns and are not currently seeing (or do not engage well with) a doctor or health professional 3. (typically, but non-essential) are facing community disadvantage, and 4. Patients NEED to be already linked with or referred to one of the following: • Ruah Community Services • 55 Central Inc. • Richmond Wellbeing • St Patricks Community Support Centre • Silver Chain • Uniting Care West • Centrecare • Salvation Army • Mission Australia • WA Blue Sky Inc. • Mercy Care • Chorus • Springboard • Or have a current Home Care Package (have an existing ACAT)
Who can refer	General Practitioner, Complex Care Coordination Service
Referral method	Complete the form (as directed by the website link) and email to screferrals@silverchain.org.au
Referral form link	https://www.silverchain.org.au/wa/referrers/refer-to-primary-care-at-home/
Cost	FREE
Contact phone	General enquires: 9242 0242

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CHRONIC CARDIAC CONDITIONS

360 Health + Community Healthy Lifestyle Program	
Relevant conditions	At risk patients, type 2 diabetes, cardiovascular disease, chronic renal disease, musculoskeletal conditions and chronic respiratory disease.
Service description	For patients at risk of or living with type 2 diabetes, cardiovascular disease, chronic renal disease, musculoskeletal conditions or chronic respiratory disease, HLP will provide patients with support to manage their health and wellbeing. Patients will learn to improve lifestyle choices to prevent or reduce the progression of chronic disease and learn how to utilise all the community resources available to further reduce their risk. The service is delivered by clinical care coordinators/chronic disease nurses and supported by the allied health team. It is a one-on-one appointment based service.
Website	360 Health + Community – HLP
Eligibility criteria	N/A
Who can refer	• GP referral • patients can contact 360 directly if they don't have a GP.
Referral method	Fax completed referral form to: 9527 1193
Referral form link	360 Health + Community – HLP/Referrals
Other information	Following a one-on-one consultation, patients will be provided with the opportunity to attend group programs to support the self-management of their condition.
Cost	Free
Location	5/51A Church Ave, Armadale 6112 (available at multiple locations across Perth metro area)
Contact phone	360 Health Centre Armadale – 1300 706 922

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Armadale Health Service- Community Rehabilitation Cardiac Rehabilitation	
Relevant conditions	Patients who have had a recent cardiovascular event or an acute exacerbation of a chronic heart condition.
Service description	Cardiac rehabilitation (CR) services are an evidence-based, multi-disciplinary intervention for high and moderate-risk patients after hospitalisation or with complex needs, who have: • had a recent cardiovascular event, surgery, or history • stable heart failure • cardiovascular risk factors • often experienced limitations in performing activities of daily living. The service includes assessments from physiotherapy, nursing and dietetics. Please note there may be wait times for appointments.
Website	Community rehabilitation (health.wa.gov.au)
Eligibility criteria	Refer to: https://wa.healthpathways.org.au/42796.htm
Who can refer	• GP • hospital staff.
Referral method	Fax completed referral form to: 9391 2262
Referral form link	Refer to: https://wa.healthpathways.org.au/42796.htm
Location	Armadale Health Service.
Cost	Free.
Contact phone	9391 2512

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Curtin University Health and Wellness Clinic	
Relevant conditions	Clients diagnosed with a cardiovascular or cardiorespiratory condition or those with CVD risk factors. People with diabetes can also join this program to improve their heart health.
Service description	This community-based, supervised exercise and rehabilitation program is for people who have experienced a cardiac event or have cardiac risk factors. The program aims to improve your fitness and help you better manage your health through education and symptom-monitoring. The program is run by an accredited exercise physiologist.
Website	Curtin – Health and Wellness Clinic
Eligibility criteria	N/A
Who can refer	• GP • hospital staff • specialist • self-referral.
Referral method	No referral required. Call 9266 1717 for details.
Referral form link	N/A
Other information	Sessions are run Monday, Tuesday and Friday mornings.
Cost	• $85 for initial assessment • $15 for single sessions (although can be purchased in blocks of 5 for $50).
Location	Curtin University, Building 404, Brand Dve, Bentley 6102
Contact phone	9266 1717

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Heart Foundation

Relevant conditions	Heart conditions.
Service description	The Heart Foundation Helpline provides free personalised information and support on heart health, nutrition and a healthy lifestyle.
Website	
Eligibility criteria	N/A
Who can refer	No referral required.
Referral method	N/A
Referral form link	N/A
Other information	Patient resources can be downloaded or ordered on the website.
Cost	Free.
Location	N/A
Contact phone	1300 36 27 87

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East Metropolitan Health Service- Aboriginal Healthy Lifestyle Programs LIFE Program (Living Improvements for Everyone)	
Relevant conditions	• Diabetes • Heart Condition • Kidney Problems • Asthma • Arthritis • Cancer or other long term illness
Service description	A course for Aboriginal people who are living with or caring for someone with a chronic condition. The aim of the LIFE course is to; • Give you the skills to self-manage your health • Understand your and/or others' illnesses • Deal with your feelings about your/others' sickness such as anger, sadness or fear • Learn how to cope with changes to your/others' life including new medicines or newly diagnosed illness
Website	East Metropolitan Health Service/Population Health
Eligibility criteria	• Aboriginal, Torres Strait Islander or Partner of an Aboriginal/TSI person • ≥18 years old
Who can refer	• Self- referral • GP/Health professional
Other information	The course runs weekly for 2.5 hours for 6 weeks
Cost	Free
Location	Multiple locations.
Contact	Email: EMHS.HealthyLifeStylePrograms@health.wa.gov.au. Ph: 9224 3778 / 9224 3749
Resources	Program Brochure

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Derbarl Yerrigan Health Service (DYHS)	
Service description	Derbarl Yerrigan Maddington offer a range of visiting programs that include; • Maternal & Child Health • Chronic Disease Management • Aboriginal Liason Officer • Indigenous Outreach • Bringing them Home • Allied Health service. • Respiratory Clinic A range of other programs are also offered at alternate Derbarl Yerrigan clinics (East Perth, Midland and Mirabooka).
Relevant disciplines	• General Practitioners • Registered Nurses • Nurse Practitioner • Aboriginal Health Practitioner • Podiatrist • Respiratory Specialist
Eligibility criteria	• Aboriginal, Torres Strait Islander or Partner of an Aboriginal/TSI person (however not a requirement)
Referral method	Phone/Walk-in
Who can refer	Anyone – walk in service
Referral form link	N/A
Cost	All services are bulk billed to those who have a Medicare card
Location	Unit 1-2, Lot 5 Binley Place Maddington WA 6109
Contact phone	Phone: (08) 9452 5333 Fax: (08) 9452 5344
Website	www.dyhs.org.au/

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ARCHE HEALTH: Wangen Murduin Integrated Team Care (ITC) Chronic Disease Program	
Service description	The Arche Health Wangen Murduin Integrated Team Care (ITC) program aims to improve the health of Aboriginal and Torres Strait Islander people who suffer from a chronic disease. The program is delivered by a team of indigenous Health Project Officers, Indigenous Outreach Workers and Care Coordinators. The service aims to provide the following assistance; • Work with your doctor to support you with your health care plans • Visit you at home • Assist you to access services • Include appropriate clinical care • Arrange appointments when required • Ensure regular GP visits • Deliver medication and assist with a medication review • Involve you in the decisions about your health care • Advocate and assist with any barriers • Follow up with your health care schedule • Assist you with transport to medical appointments
Eligibility criteria	• Aboriginal, Torres Strait Islander • One or more of the following chronic conditions; diabetes, heart disease, renal failure, respiratory conditions or cancer • Care plan completed by GP
Who can refer	• Self referral • GP • Other health professionals
Referral method	Please complete referral form and consent form and either fax to 9458 8733 or email to aht@archehealth.com.au
Referral form link	Referral form Consent form
Website	http://www.archehealth.com.au/ours-services/aboriginal-health/
Cost	Free
Location	N/A
Contact phone	Phone: (08) 9458 0505 Fax: (08) 9458 8733
Program Brochure	Wangen Murdiun ITC Brochure

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CHRONIC PAIN MANAGEMENT

East Metropolitan Health Service- Aboriginal Healthy Lifestyle Programs LIFE Program (Living Improvements for Everyone)	
Relevant conditions	• Diabetes • Heart Condition • Kidney Problems • Asthma • Arthritis • Cancer or other long term illness
Service description	A course for Aboriginal people who are living with or caring for someone with a chronic condition. The aim of the LIFE course is to; • Give you the skills to self-manage your health • Understand your and/or others' illnesses • Deal with your feelings about your/others' sickness such as anger, sadness or fear • Learn how to cope with changes to your/others' life including new medicines or newly diagnosed illness
Website	East Metropolitan Health Service/Population Health
Eligibility criteria	• Aboriginal, Torres Strait Islander or Partner of an Aboriginal/TSI person • ≥18 years old
Who can refer	• Self- referral • GP/Health professional
Other information	The course runs weekly for 2.5 hours for 6 weeks
Cost	Free
Location	Multiple locations.
Contact	Email: EMHS.HealthyLifeStylePrograms@health.wa.gov.au. Ph: 9224 3778 / 9224 3749
Resources	Program Brochure

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Arche Health Chronic Pain Management Service	
Relevant conditions	Chronic pain.
Service description	The Chronic Pain Management Service uses an outcomes-based, co-care model to firstly deliver group education sessions, followed by individual clinical sessions. These sessions cover: • medications and procedures • movement, exercise and pacing everyday activities • communicating effectively with health providers. The program begins with two group education sessions in the initial week with a multidisciplinary team consisting of a clinical psychologist, physiotherapist and pain specialist. These sessions focus on areas such as 'making sense of your pain', 'improving function' and 'getting your nervous system back onside'. The Chronic Pain Management Service Co-ordinator will then organise individual clinics 4-6 weeks after the initial group sessions with each specialist to discuss their personal journey.
Website	Chronic Pain Management Service
Eligibility criteria	• over 18 years old • referred with a chronic pain (longer than three months) • suitable for participation in group education • agree to complete a pre-entry questionnaire to assist in the triaging process • have an English language capacity sufficient to understand the written and verbal materials being presented • be able to give voluntary, informed consent for ongoing collection of audit data **Exclusion criteria**: palliative cancer pain, unstable mental health condition, incarcerated patients or patients already receiving intervention from a pain specialist. Some exceptions may apply.
Who can refer	General Practitioner or Physiotherapist
Referral method	Fax completed referral form to 9458 8733
Other information	All participants of the group education and individual clinics are then offered to join the Stanford Chronic Pain Self-Management course, which runs for 2.5 hours, once a week for 6 weeks, and assists each patient to manage their pain through various techniques such as better breathing, physical activity and positive thinking. Participants also learn a short flexibility routine developed for people with chronic pain, called the Moving Easy Program.
Cost	Free
Location	Unit 4/1140 Albany Highway Bentley, Western Australia 6102
Contact phone	9458 0505

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CHRONIC RENAL DISEASE

ARCHE HEALTH: Wangen Murduin Integrated Team Care (ITC) Chronic Disease Program	
Service description	The Arche Health Wangen Murduin Integrated Team Care (ITC) program aims to improve the health of Aboriginal and Torres Strait Islander people who suffer from a chronic disease. The program is delivered by a team of indigenous Health Project Officers, Indigenous Outreach Workers and Care Coordinators. The service aims to provide the following assistance; • Work with your doctor to support you with your health care plans • Visit you at home • Assist you to access services • Include appropriate clinical care • Arrange appointments when required • Ensure regular GP visits • Deliver medication and assist with a medication review • Involve you in the decisions about your health care • Advocate and assist with any barriers • Follow up with your health care schedule • Assist you with transport to medical appointments
Eligibility criteria	• Aboriginal, Torres Strait Islander • One or more of the following chronic conditions; diabetes, heart disease, renal failure, respiratory conditions or cancer • Care plan completed by GP
Who can refer	• Self referral • GP • Other health professionals
Referral method	Please complete referral form and consent form and either fax to 9458 8733 or email to aht@archehealth.com.au
Referral form link	Referral form Consent form
Website	Aboriginal Health Programs - Arche Health Limited
Cost	Free
Location	N/A
Contact phone	Phone: (08) 9458 0505 Fax: (08) 9458 8733
Program Brochure	Wangen Murdiun ITC Brochure

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360 Health + Community Healthy Lifestyle Program	
Relevant conditions	At risk patients, type 2 diabetes, cardiovascular disease, chronic renal disease, musculoskeletal conditions and chronic respiratory disease.
Service description	For patients at risk of or living with type 2 diabetes, cardiovascular disease, chronic renal disease, musculoskeletal conditions or chronic respiratory disease, HLP will provide patients with support to manage their health and wellbeing. Patients will learn to improve lifestyle choices to prevent or reduce the progression of chronic disease and learn how to utilise all the community resources available to further reduce their risk. The service is delivered by clinical care coordinators/chronic disease nurses and supported by the allied health team. It is a one-on-one appointment based service.
Website	360 Health + Community – HLP
Eligibility criteria	N/A
Who can refer	• GP referral • patient can contact 360 directly if they don't have a GP.
Referral method	Fax completed referral form to: 9527 1193
Referral form link	360 Health Referrals | Health Services Provider WA | 360H+C
Other information	Following a one-on-one consultation, patients will be provided with the opportunity to attend group programs to support the self-management of their condition.
Cost	Free
Location	5/51A Church Ave, Armadale, 6112 (available at multiple locations across Perth metro area)
Contact phone	360 Health Centre Armadale – 1300 706 922

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CHRONIC RESPIRATORY CONDITIONS

360 Health + Community Healthy Lifestyle Program	
Relevant conditions	At risk patients, type 2 diabetes, cardiovascular disease, chronic renal disease, musculoskeletal conditions and chronic respiratory disease.
Service description	For patients at risk of or living with type 2 diabetes, cardiovascular disease, chronic renal disease, musculoskeletal conditions or chronic respiratory disease, HLP will provide patients with support to manage their health and wellbeing. Patients will learn to improve lifestyle choices to prevent or reduce the progression of chronic disease and learn how to utilise all the community resources available to further reduce their risk. The service is delivered by clinical care coordinators/chronic disease nurses and supported by the allied health team. It is a one-on-one appointment based service.
Website	360 Health + Community – HLP
Eligibility criteria	N/A
Who can refer	• GP referral • patient can contact 360 directly if they don't have a GP.
Referral method	Fax completed referral form to: 9527 1193
Referral form link	360 Health Referrals | Health Services Provider WA | 360H+C
Other information	Following a one-on-one consultation, patients will be provided with the opportunity to attend group programs to support the self-management of their condition.
Cost	Free
Location	5/51A Church Ave, Armadale, 6112 (available at multiple locations across Perth metro area)
Contact phone	360 Health Centre Armadale – 1300 706 922

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Armadale Health Service - Community Rehabilitation Pulmonary Rehabilitation	
Relevant conditions	Patients with a chronic lung disease.
Service description	Pulmonary rehabilitation is a supervised exercise and information program which: • is valuable for many chronic lung conditions • has been proven to reduce symptoms and their severity, as well as reduce the chance of being hospitalised for COPD • helps to increase fitness which improves cardiovascular function and builds strength in muscles crucial to improve breathing. Please note there may be wait times for appointments.
Website	Community rehabilitation (health.wa.gov.au)
Eligibility criteria	Refer to https://wa.healthpathways.org.au/11652_1.htm
Who can refer	• GP • hospital staff.
Referral method	Fax completed referral form to: 9391 2262
Referral form link	Refer to https://wa.healthpathways.org.au/index.htm?11652_1.htm
Other information	N/A
Cost	Free.
Location	Armadale Health Service.
Contact phone	9391 2512

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Lung Foundation	
Relevant conditions	Chronic lung condition.
Service description	Lung Foundation is a national charity dedicated to support anyone with a lung disease. The foundation aims to provide support by: • promoting the importance of lung health • promoting early diagnosis of lung disease • supporting those with lung disease, their families and carers • promoting equitable access to evidence-based care • funding quality research.
Website	https://lungfoundation.com.au/
Eligibility criteria	N/A
Who can refer	No referral required.
Other information	Patient resources can be downloaded or ordered on the website.
Cost	Free.
Location	Pulmonary rehabilitation and support group locations can be found on the website.
Contact phone	1800 654 301

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East Metropolitan Health Service- Aboriginal Healthy Lifestyle Programs LIFE Program (Living Improvements for Everyone)	
Relevant conditions	• Diabetes • Heart Condition • Kidney Problems • Asthma • Arthritis • Cancer or other long term illness
Service description	A course for Aboriginal people who are living with or caring for someone with a chronic condition. The aim of the LIFE course is to; • Give you the skills to self-manage your health • Understand your and/or others' illnesses • Deal with your feelings about your/others' sickness such as anger, sadness or fear • Learn how to cope with changes to your/others' life including new medicines or newly diagnosed illness
Website	East Metropolitan Health Service/Population Health
Eligibility criteria	• Aboriginal, Torres Strait Islander or Partner of an Aboriginal/TSI person • ≥18 years old
Who can refer	• Self- referral • GP/Health professional
Other information	The course runs weekly for 2.5 hours for 6 weeks
Cost	Free
Location	Multiple locations.
Contact	Email: EMHS.HealthyLifeStylePrograms@health.wa.gov.au. Ph: 9224 3778 / 9224 3749
Resources	Program Brochure

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Silver Chain Respiratory Care	
Relevant conditions	Chronic respiratory condition.
Service description	All clients on domiciliary oxygen in the community have access to: • respiratory nurse – 3 monthly visits (or more if required) • allied health – social worker, physio and dietitian • priority response pre–approval (PRA service) • respiratory physician • hospital liaison nurse • service also provides comprehensive multidisciplinary team management, education and GP liaison assistance.
Website	Silver Chain – Respiratory Care
Eligibility criteria	Must meet prescription criteria for Domiciliary Oxygen (see referral form) Do not service: • nursing homes • DVA • country regions.
Who can refer	Metro areas – Physician Rural areas – Physician or GP
Referral method	Fax: 9444 7265
Cost	Free
Location	Service provided in the client's home. Metropolitan region spanning from Hamel in the south to Two Rocks in the North.
Contact phone	9242 0242

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Derbarl Yerrigan Health Service (DYHS)	
Service description	Derbarl Yerrigan Maddington offer a range of visiting programs that include; • Maternal & Child Health • Chronic Disease Management • Aboriginal Liason Officer • Indigenous Outreach • Bringing them Home • Allied Health service. • Respiratory Clinic A range of other programs are also offered at alternate Derbarl Yerrigan clinics (East Perth, Midland and Mirabooka).
Relevant disciplines	• General Practitioners • Registered Nurses • Nurse Practitioner • Aboriginal Health Practitioner • Podiatrist • Respiratory Specialist
Eligibility criteria	• Aboriginal, Torres Strait Islander or Partner of an Aboriginal/TSI person (however not a requirement)
Referral method	Phone/Walk-in
Who can refer	Anyone – walk in service
Referral form link	N/A
Cost	All services are bulk billed to those who have a Medicare card
Location	Unit 1-2, Lot 5 Binley Place Maddington WA 6109
Contact phone	Phone: (08) 9452 5333 Fax: (08) 9452 5344
Website	www.dyhs.org.au/

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COGNITION AND MEMORY

Dementia Australia	
Relevant conditions	Alzheimer's disease
Service description	Provides specialist services to people with dementia and their families/carers, including: • National Dementia Helpline • Carer's Support Groups • Carer Support and Information Program • Dementia Enavling Environments Project • Counselling • Education Workshops • Behaviour Management Advisory Service • Respite Options • Art Programmes.
Website	Dementia Australia
Eligibility criteria	N/A
Who can refer	Self-referral
Referral method	Phone: 9388 2800
Cost	Most services are free. Some may require a payment depending on the patient.
Location	55 Walters Drive, Osborne Park 6017
Contact phone	Osborne Park Head Office: 9388 2800 Dementia Helpline: 1800 100 500

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McCusker Nurse Service	
Service description	The McCusker Nurse Service provides free support for the carers of those living with dementia The McCusker Nurse is a dementia expert, who can help carers and families understand the condition and navigate the support options available to them at any stage in the illness. Your McCusker Nurse walks alongside you, to improve wellbeing and quality of life for both you and the person living with dementia. By accessing suitable support, the person with dementia is often able to live in their own home for longer with services delivered to them, only moving into residential care when the time is right.
Website	McCusker Nurse
Eligibility criteria	Client must be living within specific areas north and south of the Swan River in Perth. Call the number listed below to check eligibility
Who can refer	• Self-referral/ family • Health professional
Referral method and Contact details	Call or email McCusker Nurse South Ph: 9424 6697 Mobile: 0437 110 928 Email: McCuskerNurseSouth@amanaliving.com.au McCusker Nurse North Ph: 9424 6396 Mobile: 0417 519 253 Email: McCuskerNurseNorth@amanaliving.com.au
Location	McCusker Nurse South Club Lefroy, 22 Lefroy Rd Bull Creek WA 6149 McCusker Nurse North 541 Hay street Subiaco WA 6008

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CONTINENCE ASSISTANCE

Armadale Health Service Continence Clinic	
Service description	Our Continence Clinic is coordinated by nurses who are trained continence advisors and are able to offer assessment, advice, treatment and support for adults with continence issues. Our services include: • assessment and plan of care • conservative management • education regarding good bladder habits – fluids, diet • pelvic muscles exercises • bladder drill and deferment techniques • teaching intermittent self-catheterisation, IDC care, self-dilatation etc • information on aids and appliances as well as samples • assistance to access eligible subsidy schemes • follow up in community if necessary
Website	https://www.ahs.healthhttps://www.ahs.health.wa.gov.au/Our-services/Continence-Clinic.wa.gov.au/Our-services/Continence-Clinic
Who can refer	• Specialists (Urologists, Gynaecologists) • General Practitioners • Patients (self-referral)
Referral method	Fax to 9391 2262
Cost	FREE
Location	Armadale Health Service
Contact phone	(08) 9391 2665

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Bladder and Bowel Health Australia	
Relevant conditions	Continence concerns.
Service description	Provides education, advice and information to people with bladder and/or bowel health issues, their carer's, families, health care professionals, support workers and special needs groups.
Website	Bladder and Bowel
Eligibility criteria	No criteria.
Who can refer	Self-referral.
Referral method	Phone 1800 330 066 to speak to a qualified continence nurse.
Cost	Free.
Location	Suite 5, The Perron Centre 61 Kitchener Avenue Victoria Park WA 6100
Contact phone	1800 330 066

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Continence Aids Payment Scheme

Relevant conditions	Permanent and severe bladder or bowel incontinence
Service description	Medicare funded scheme to assist with the cost of continence aids
Website	CAPS
Eligibility criteria	To get the Continence Aids Payment Scheme (CAPS) you must: • be 5 years or older • have permanent and severe bladder or bowel incontinence • have one of the eligible neurological or other eligible conditions on the bladder and bowel website, and • be able to get a Pensioner Concession Card from us or the Department of Veterans' Affairs (DVA), if your condition is not neurological - this can be as the main card holder or a dependent

Exclusion criteria	You are in-eligible if;
	• you get home or residential care under the *Aged Care Act 1997*, and your care plan includes continence aids
	• you have a DVA Gold Card or White Card, and can get help through the DVA Rehabilitation Appliances Program
	• you have a funding package from the National Disability Insurance Scheme, and it includes continence aids
	• your incontinence:
	  ○ will go away
	  ○ is treatable, for example with pelvic floor exercises, bladder retraining, medicine or surgery
	  ○ is night time bed wetting only
	• you're in prison, or
	• you've been living overseas for 3 or more years in a row

Who can refer	Health professional
Referral form link	CAPS referral form An electronic copy can be requested by emailing continence@health.gov.au
Other information	Patients are able to access BOTH the Medicare funded CAPS assistance and the state funded CMAS scheme (see next page)
Contact phone	1800 239 309

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Continence Management and Advisory Service (CMAS)	
Relevant conditions	Bladder and/or bowel problems
Service description	The Continence Management and Advisory Service provide expert care and advice to people with bladder and/or bowel problems. It is a free service, funded by the West Australian Government. Our trained nurses can support you to manage and improve your condition through personalised management strategies including continence management plans, appropriate routines, bladder training, dietary suggestions, counselling and advice. If you require continence products, we will discuss what's available and help you make the best choice. Depending on your situation, we may refer you to the Continence Management and Subsidy Scheme (CMASS) to receive subsidised continence products
Website	https://healthywa.wa.gov.au/Articles/A_E/Continence-management-and-advice
Eligibility criteria	• Aged over 16 years. • Holder of Pensioner Concession Card OR Health Care Card. • Chronic incontinence for longer than 6 months. • Clients receiving **High Care Aged Care are NOT eligible** whereas **clients in Low Care are eligible** if they meet the criteria above. • Clients with disabilities living in residential care facilities are eligible for CMAS if they do NOT receive a 'Home Care Package' Level 3 or 4.
Who can refer	Health Professional
Referral method	Complete and Fax to 9444 7265
Other information	Patients are able to access both the state funded CMAS scheme and the Medicare funded CAPS assistance (see previous page)
Cost	Free
Location	Various locations
Contact phone	1300 787 055

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DIABETES

ABORIGINAL HEALTHY LIFESTYLE PROGRAMS (EMHS): The Journey of Living with Diabetes Program	
Relevant conditions	Type 2 Diabetes
Service description	This program is for Aboriginal people who have Type 2 diabetes. It was developed to help Aboriginal people to manage their diabetes. The program is run in groups and led by a trained Aboriginal health professional. Discussion and sharing stories are used to help you learn about your diabetes and how you can make changes to best look after your health
Eligibility criteria	• Aboriginal, Torres Strait Islander or Partner of an Aboriginal/TSI person • ≥18 years old
Who can refer	• GP/Health professional • Self-referral (however requires doctors clearance)
Referral method	N/A
Referral form link	N/A
Other information	The program is run over 6-8 sessions Programs are held locally and transport can be arranged. Families are welcome.
Cost	Free
Location	Multiple locations
Website	https://www.emhs.health.wa.gov.au/Hospitals-and-Services/Aboriginal-Health/AHLPHealth/AHLP
Contact phone	Email: EMHS.HealthyLifeStylePrograms@health.wa.gov.au. Ph: 9224 1981
Resources	Program Brochure

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ABORIGINAL HEALTHY LIFESTYLE PROGRAMS (EMHS): Moorditj Djena (Strong Feet)	
Service description	Moorditj Djena (Strong Feet) – Moorditj Djena is a podiatry and diabetes education outreach program for Aboriginal people within the Perth metropolitan area. Culturally appropriate podiatry and diabetes education for Aboriginal people is provided with a focus on prevention and management of foot complications and their risk factors such as diabetes, peripheral arterial disease, peripheral neuropathy and other chronic diseases. Services include: • Podiatry for assessment, treatment and education of all foot related concerns. This covers wound care, nail surgery, biomechanical assessment and orthotic provision. Education is also given regards choosing the correct footwear and how to look after your feet. • Aboriginal Health Workers for health interventions for prevention methods, health education, support and advocacy. • Dietitian to discuss healthy eating for diabetes and other chronic conditions, including ideas for shopping on a budget, cooking healthier meals and providing recipes. • Diabetes Educator to help clients self-manage their diabetes effectively and prevent complications.
Relevant conditions	• Diabetes • Vascular Disease, • Neuropathy • Obesity • Foot Deformity • Ulceration • Chronic foot problems
Eligibility criteria	• Aboriginal, Torres Strait Islander or Partner of an Aboriginal/ Torres Strait Islander person • ≥18 years old
Location	Multiple locations. Mobile vans that service the northern, southern and eastern metropolitan areas of Perth. Call for details.
Who can refer	Patients can self-refer. Health professionals can provide referrals/handovers for collateral information (GP, Allied Health Staff and Nurses).
Referral method	Walk-in appointments, or contact/book through phone, fax or email.
Contact Details	Phone: (08) 9278 9922 Fax: (08) 9250 1419 Email: moorditjdjena@health.wa.gov.au
Cost	Free
Website	https://emhs.health.wa.gov.au/Hospitals-and-Services/Aboriginal-Health/Moorditj-Djena
Resources	Program Brochure

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ABORIGINAL HEALTHY LIFESTYLE PROGRAMS (EMHS): Living Improvements for Everyone (LIFE) Program	
Service description	A course for Aboriginal people who are living with or caring for someone with a chronic condition. The aim of the LIFE course is to; • Give you the skills to self-manage your health • Understand your and/or others' illnesses • Deal with your feelings about your/others' sickness such as anger, sadness or fear • Learn how to cope with changes to your/others' life including new medicines or newly diagnosed illness
Relevant conditions	• Diabetes • Heart Condition • Kidney Problems • Asthma • Arthritis • Cancer or other long term illness
Eligibility criteria	• Aboriginal, Torres Strait Islander or Partner of an Aboriginal/TSI person • ≥18 years old
Who can refer	• Self- referral • GP/Health professional
Other information	The course runs weekly for 2.5 hours for 6 weeks
Cost	Free
Location	Multiple locations.
Website	https://www.emhs.health.wa.gov.au/Hospitals-and-Services/Aboriginal-Health/AHLP
Contact	Email: EMHS.HealthyLifeStylePrograms@health.wa.gov.au. Ph: 9224 3778 / 9224 3749
Resources	LIFE Program Brochure

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Derbarl Yerrigan Health Service (DYHS)	
Service description	Derbarl Yerrigan Maddington offer a range of visiting programs that include; • Maternal & Child Health • Chronic Disease Management • Aboriginal Liason Officer • Indigenous Outreach • Bringing them Home • Allied Health service. • Respiratory Clinic A range of other programs are also offered at alternate Derbarl Yerrigan clinics (East Perth, Midland and Mirabooka).
Relevant disciplines	• General Practitioners • Registered Nurses • Nurse Practitioner • Aboriginal Health Practitioner • Podiatrist • Respiratory Specialist
Eligibility criteria	• Aboriginal, Torres Strait Islander or Partner of an Aboriginal/TSI person (however not a requirement)
Referral method	Phone/Walk-in
Who can refer	Anyone – walk in service
Referral form link	N/A
Cost	All services are bulk billed to those who have a Medicare card
Location	Unit 1-2, Lot 5 Binley Place Maddington WA 6109
Contact phone	Phone: (08) 9452 5333 Fax: (08) 9452 5344
Website	www.dyhs.org.au/

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ARCHE HEALTH: Wangen Murduin Integrated Team Care (ITC) Chronic Disease Program	
Service description	The Arche Health Wangen Murduin Integrated Team Care (ITC) program aims to improve the health of Aboriginal and Torres Strait Islander people who suffer from a chronic disease. The program is delivered by a team of indigenous Health Project Officers, Indigenous Outreach Workers and Care Coordinators. The service aims to provide the following assistance; • Work with your doctor to support you with your health care plans • Visit you at home • Assist you to access services • Include appropriate clinical care • Arrange appointments when required • Ensure regular GP visits • Deliver medication and assist with a medication review • Involve you in the decisions about your health care • Advocate and assist with any barriers • Follow up with your health care schedule • Assist you with transport to medical appointments
Eligibility criteria	• Aboriginal, Torres Strait Islander • One or more of the following chronic conditions; diabetes, heart disease, renal failure, respiratory conditions or cancer • Care plan completed by GP
Who can refer	• Self referral • GP • Other health professionals
Referral method	Please complete referral form and consent form and either fax to 9458 8733 or email to aht@archehealth.com.au
Referral form link	Referral form Consent form
Website	Aboriginal Health Programs - Arche Health Limited
Cost	Free
Location	N/A
Contact phone	Phone: (08) 9458 0505 Fax: (08) 9458 8733
Program Brochure	Wangen Murdiun ITC Brochure

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360 Health + Community Diabetes Education	
Relevant conditions	Type 2 diabetes.
Service description	Diabetes education sessions will provide a personalised plan addressing a number of elements of diabetes management, including diabetes pathophysiology, disease progression and complications, blood glucose monitoring, HbA1c and blood glucose target range, healthy eating guidelines and medication options. Sessions are delivered one-on-one by diabetes educators and credentialed diabetes educators.
Website	360 Health + Community – Diabetes Education
Eligibility criteria	N/A
Who can refer	• allied health referral • GP referral • self-referral.
Referral method	Fax completed referral form to: 9527 1193 If patient is self-referring contact 1300 706 922 to speak to the team.
Referral form link	360 Health + Community – Diabetes Education/Referral form
Other information	Referral not needed. Anyone can access diabetes education sessions.
Cost	Variable. Subsidies are available for eligible participants, and rebates are available from most major health funds.
Location	5/51A Church Ave, Armadale 6112 (available at multiple locations across Perth metro area)
Contact phone	360 Health Centre Armadale – 1300 706 922

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360 Health + Community
Coordinated Endocrinology and Diabetes Service (CEDS)

Relevant conditions	Type 1 and type 2 diabetes
Service description	CEDS is an endocrinologist clinic that aims to improve clinical outcomes for patients with type 1 diabetes, complex type 2 diabetes or general endocrinology conditions. CEDS provides weekly access to a specialist endocrinologist to help patients manage their condition, as well as access to a diabetes educator, dietitian and exercise physiologist to provide ongoing lifestyle advice to help patients control their condition in their day-to-day life.
Website	360 Health + Community – CEDS
Eligibility criteria	N/A
Who can refer	• GP referral • patient can contact 360 directly if they don't have a GP.
Referral method	Fax completed referral form to: 9527 1193
Referral form link	360 Health + Community – CEDS/Referral form
Cost	Access to the endocrinologist is a bulk bill service, with a $30 out of pocket fee applying for all allied health sessions. Pension and health care card holders can access all services for free.
Location	5/51A Church Ave, Armadale 6112 (available at multiple locations across Perth metro area)
Contact phone	360 Health Centre Armadale – 1300 706 922

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360 Health + Community Healthy Lifestyle Program	
Relevant conditions	At risk patients, type 2 diabetes, cardiovascular disease, chronic renal disease, musculoskeletal conditions and chronic respiratory disease.
Service description	For patients at risk of or living with type 2 diabetes, cardiovascular disease, chronic renal disease, musculoskeletal conditions or chronic respiratory disease, HLP will provide patients with support to manage their health and wellbeing. Patients will learn to improve lifestyle choices to prevent or reduce the progression of chronic disease and learn how to utilise all the community resources available to further reduce their risk. The service is delivered by clinical care coordinators/chronic disease nurses and supported by the allied health team. It is a one-on-one appointment based service.
Website	360 Health + Community – HLP
Eligibility criteria	N/A
Who can refer	• GP referral • patients can contact 360 directly if they don't have a GP.
Referral method	Fax completed referral form to: 9527 1193
Referral form link	360 Health + Community – HLP/Referrals
Other information	Following a one-on-one consultation, patients will be provided with the opportunity to attend group programs to support the self-management of their condition.
Cost	Free
Location	5/51A Church Ave, Armadale 6112 (available at multiple locations across Perth metro area)
Contact phone	360 Health Centre Armadale – 1300 706 922

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Armadale Health Service Adult Diabetes Service – Diabetes Education	
Relevant conditions	Type 1 diabetes, complex type 2 diabetes and gestational diabetes mellitus.
Service description	Our diabetes educators and dietitians provide individual appointments for patients with type 1 diabetes, complex type 2 diabetes and gestational diabetes mellitus. Please note there may be wait times for appointments.
Website	Armadale Health Service – Adult Diabetes Service
Eligibility criteria	Refer to https://wa.healthpathways.org.au/278257.htm
Who can refer	• allied health • GP • nurse.
Referral method	Fax: 9391 2229 Post: Armadale Community Health PO Box 460 Armadale, WA 6995
Referral form link	Refer to https://wa.healthpathways.org.au/278257.htm
Other information	N/A
Cost	Free.
Location	Armadale Community Health and Development Centre 3056 Albany Highway, Armadale 6112
Contact phone	9391 1111

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For a comprehensive directory of diabetes educators please visit the National Health Services Directory. These services can be accessed through a GP Management Plan.

Armadale Health Service Multidisciplinary Diabetes Service	
Relevant conditions	Type 1 diabetes and complex type 2 diabetes.
Service description	Multidisciplinary team consisting of medical physician, dietitian and diabetes educator providing management, education, review and treatment of non-acute diabetes.
Website	HealthPathways – Non acute Diabetes Assessment
Eligibility criteria	For inclusion and exclusion criteria please refer to https://wa.healthpathways.org.au/70269.htm
Who can refer	GPs
Referral method	All referrals must go through the Central Referral System.
Referral form link	Central Referral System – General Adult form
Other information	N/A
Cost	Free.
Location	N/A
Contact phone	9391 1118

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Diabetes WA DESMOND	
Relevant conditions	Type 2 diabetes.
Service description	DESMOND is an ongoing workshop where participants can interact with other people also living with type 2 diabetes, while learning practical self-management advice for the prevention of complications. The workshops cover a variety of relevant topics, including food choices, exercise, blood glucose monitoring, goal setting and action plans, all delivered in a friendly, supportive environment. DESMOND is led by specially trained dietitians and diabetes educators.
Website	DESMOND
Eligibility criteria	N/A
Who can refer	• allied health referral • GP referral • self-referral.
Referral method	Bookings are essential. To reserve a spot in a DESMOND workshop **book online** or call Diabetes WA
Other information	DESMOND workshops are held regularly throughout the year with a review session one month after attendance. Contact Diabetes WA
Cost	DESMOND is a free workshop for NDSS registrants and Diabetes WA members.
Location	Various locations
Contact phone	1300 001 880 (Mon-Fr 8.30am – 4.30 pm).

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Curtin University Health & Wellness Clinic	
Relevant conditions	Clients diagnosed with a cardiovascular or cardiorespiratory condition or those with CVD risk factors. People with diabetes can also join this program to improve their heart health.
Service description	This community-based, supervised exercise and rehabilitation program is for people who have experienced a cardiac event or have cardiac risk factors. The program aims to improve your fitness and help you better manage your health through education and symptom-monitoring. The program is run by an accredited exercise physiologist.
Website	Curtin University – Health & Wellness Clinic
Eligibility criteria	N/A
Who can refer	• GP • hospital staff • specialist • self-referral.
Referral method	No referral required. Call 9266 1717 for details.
Referral form link	N/A
Other information	Sessions are run Monday, Tuesday and Friday mornings.
Cost	• $85 for initial assessment • $15 for single sessions (although can be purchased in blocks of 5 for $50).
Location	Curtin University, Building 404, Brand Dve, Bentley 6102
Contact phone	9266 1717

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Diabetes WA Diabetes WA Information and Advice Line (DIAL)	
Relevant conditions	Type 1 diabetes and type 2 diabetes.
Service description	The Diabetes WA Information and Advice Line (DIAL) is a telephone call back service manned by credentialed diabetes educators. Educators are trained to help patients best manage their diabetes. They can provide information, education and counselling on all aspects of diabetes care, as well as helping patients to problem solve and manage any issues that arise. They can also refer patients on to other healthcare professionals or services should the need arise.
Website	https://wa.healthpathways.org.au/23168.htm
Eligibility criteria	N/A
Who can refer	Self-referral.
Referral method	Phone: 1300 136 588 Email: info@diabeteswa.com.au
Referral form link	N/A
Other information	Patients should call Diabetes WA and ask to speak with a DIAL diabetes educator. Diabetes WA will take down the patient's details, and a credentialed diabetes educator will call the back as soon as possible. All telephone conversations are confidential. Patients can also email a credentialed diabetes educator for a confidential written response. Available 8:30am – 4:30pm weekdays.
Cost	The cost of a local call.
Location	By phone.
Contact phone	1300 136 588

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Private Credentialed Diabetes Educators

Relevant conditions	Type 1 diabetes and type 2 diabetes.
Service description	Credentialed diabetes educators can help patients with: • better diabetes management • self-blood glucose monitoring • oral hypoglycaemic agents • insulin initiation and titration • sick day rules • hypoglycaemia recognition and management • problem solving for fluctuations in blood glucose levels • understanding how nutrition influences blood glucose control • understanding the benefits of physical activity.
Website	https://wa.healthpathways.org.au/23168.htm
Eligibility criteria	N/A
Who can refer	GP.
Referral method	Consider if your patient would benefit from a GP Management Plan.
Referral form link	N/A
Other information	Find a local Diabetes Educator: Australian Diabetes Educators Association
Cost	Varies per provider.
Location	Various locations.
Contact phone	N/A

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For a comprehensive directory of dietitians please visit the National Health Services Directory. These services can be accessed through a GP Management Plan.

EQUIPMENT NEEDS

Independent Living Centre	
Service description	Independent Living Centre health professionals help people choose and access equipment, technology and services. Includes purchasing, hiring and second hand equipment. Also provide allied health services in the home and community, including assessment, prescription, training and support to use assistive equipment and technology.
Website	Independent Living Centre
Eligibility criteria	N/A
Who can refer	No referral required
Referral method	Drop in service
Cost	Information and advisory service is free. Further assistive equipment and technology support services may attract a fee.
Location	ILC Cockburn – Smart Home Display, Assistive Equipment and Technology: Suite 6B, Ground Floor, Cockburn Integrated Health and Community Facility, 11 Wentworth Parade, Success 6164
Contact phone	Phone: 9381 0600 Fax: 9381 0611

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EXERCISE GROUPS

East Metropolitan Health Service- Aboriginal Healthy Lifestyle Programs I'm Moordidjabinj (Becoming Strong)	
Service description	I'm Moordidjabinj (Becoming Strong) is a healthy lifestyle, nutritional education program designed to help community members change unhealthy lifestyles, improve fitness and make health food choices. The program includes exercise, education and cooking sessions
Website	East Metropolitan Health Service/Population Health
Eligibility criteria	• Aboriginal, Torres Strait Islander or Partner of an Aboriginal/TSI person • ≥18 years old
Who can refer	• Self- referral • GP/Health professional
Other information	The program is a 6 week program
Cost	Free
Location	Multiple locations
Contact phone	Email: EMHS.HealthyLifeStylePrograms@health.wa.gov.au. Ph: 9224 3778 / 9224 3749
Resources	Program Brochure

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Exercise Groups	
Service description	Activities such as water walkers and walking groups
Cost	Free/varies dependant on activity
Services	Armadale Mall Walkers Address: Armadale Shopping Centre Phone: 9399 3933 Website: City of Armadale – Seniors Prime Movers Address: Multiple locations Website: Prime Movers for timetable and contact details Water Walkers Address: Armadale Aquatic Centre Phone: 9399 3225 Website: City of Armadale – Seniors Gosnells Walking Group Address: Centennial Pioneer Park, Gosnells Website: City of Gosnells – Walking and Cycling Maddington Walking Group Address: Attfield Street, Maddington Website: City of Gosnells- Maddington Walking Group

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HOSPITAL AVOIDANCE AND DISCHARGE SUPPORT

Silver Chain Home Hospital	
Service description	Provides patients with hospital-level care in their own home. Service provided by medical practitioners, nurse practitioners and nurses who provide high-level acute care, normally provided in a hospital or ED. See website for list of common treatments.
Website	Silver Chain – Home Hospital
Eligibility criteria	Patients must: • be living at home or in a residential care facility • require short term acute and sub-acute care that can be delivered safely in the home • not require an emergency response and be safe to wait up to four hours • be aged 13 and over • be no more than 22 weeks pregnant • be able to communicate effectively, directly or through an interpreter • be medically and mentally stable • be Medicare eligible • have given their consent.
Who can refer	• GP • specialist • community nurse • health direct • residential aged care facility (RACF) • hospital staff • ED
Referral method	Fax referral form and ALN will call to discuss referral Fax: 9444 7265
Referral form link	Home Hospital
Other information	N/A
Cost	Free or contribution towards the cost.
Location	Service provided in patients home.
Contact phone	Ph: 1300 466 346

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Silver Chain Hospital Discharge Support (HDS)	
Service description	Hospital Discharge Support is rapid response service which provides support to you in the community. It will help you recover from a recent illness or surgery. Our allied health team will assess you in your home and design a short-term program around your own goals. The length of time you will spend in the program depends on your individual needs. Our aim is to get you back on your feet and help you avoid a return to hospital. HDS is an Allied Health led, evidence based, reablement service for clients coming out of hospital. HDS aims to support the successful discharge of clients and prevent unnecessary readmission. HDS includes setting up the home environment successfully for the client, falls prevention and reablement towards activities the person was doing prior to their hospital stay. The program goals, types of supports, services and frequency of visits are determined by the Silver Chain Allied Health Professional in conjunction with the client following assessment. HDS Services are delivered between 7am and 5pm, Monday to Friday.
Website	Silver Chain – Hospital Discharge Support
Eligibility criteria	Patient's must: • Be in hospital at the time of the referral • Be medically stable • Reside in an area where Hospital Discharge Support is available. • Patient must have a functional need which requires Personal Care as part of the service (Previous HACC eligibility will be applied) Not Eligible: • Private patients in private hospitals • Patients with NDIS funding • Patients in receipt of a Home Care Package (they may be able to receive an HDS service funded through their package and should check with their provider if this is possible), or they may be able to access Allied Health Reablement services via CHSP • Clients awaiting a Home Care Package (they may be able to access Allied Health Restorative Care Services through CHSP). They can be referred to My Aged Care. • HDS is available to eligible clients for up to 6 weeks. HDS clients may be referred to other services where their needs exceed a 6-week service.
Who can refer	• Medical • Allied Health • Nursing
Referral method	Weekdays: between 8:30am and 4:30pmreferrals can be made to Allied Health Liaison via phone (9242 0347). Be prepared to answer questions relating to the patient by way of a phone

	screening. After hours: between 4:30pm and 11pm weekdays, weekends and public holidays referrals can be made to ALN's from ED or equivalent only via phone (9242 0347). A phone screening tool is used.
Cost	FREE
Contact phone	Allied Health Liaison 9242 0347

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Silver Chain Priority Response Assessment	
Service description	Priority Response Assessment: 24/7 assessment service that provides advanced clinical assessment in patients home or residential care facility within a four hour response period, therefore avoiding Emergency Department attendance.
Website	Silver Chain – PRA
Eligibility criteria	Patients must: • be living at home or in a residential care facility • require short term acute and sub-acute care that can be delivered safely in the home • not require an emergency response and be safe to wait up to four hours • be aged 13 and over • be no more than 22 weeks pregnant • be able to communicate effectively, directly or through an interpreter • be medically and mentally stable • be Medicare eligible • have given their consent. • If patient has COPD, patient requires COPD management plan
Who can refer	• GP • specialist • medical hospital staff • residential aged care facility (RACF)
Referral method	Phone: 1300 466 346 to speak with Ambulatory Liaison Nurses.
Cost	Free
Location	Service provided in patients home.
Contact phone	1300 466 346

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Silver Chain Primary Care at Home	
Service description	PCAH is designed to reconnect vulnerable and disadvantaged people in the Perth metro area with the primary health services they need. We can help your clients manage their health concerns, alleviating a major source of stress for them and their support network. If you have clients who've have had difficulties connecting with GPs, understanding health matters or are simply disconnected from the health care system, we can help. Our Nurse Practitioners create a trusted bridge between clients and health professionals, including medication management and referrals as well as supporting applications for additional services like transportation and help around the home. Wait times are minimal for the program. We will contact you or your client within 7 days.
Website	www.silverchain.org.au/wa/referrers/refer-to-primary-care-at-home/
Eligibility criteria	Referral requirements: 1. Live in metropolitan Perth (Two Rocks to Pinjarra) 2. Have health concerns and are not currently seeing (or do not engage well with) a doctor or health professional 3. (typically, but non-essential) are facing community disadvantage, and 4. Patients NEED to be already linked with or referred to one of the following: • Ruah Community Services • 55 Central Inc. • Richmond Wellbeing • St Patricks Community Support Centre • Silver Chain • Uniting Care West • Centrecare • Salvation Army • Mission Australia • WA Blue Sky Inc. • Mercy Care • Chorus • Springboard • Or have a current Home Care Package (have an existing ACAT)
Who can refer	Complex Care Coordination Service
Referral method	Complete the form (as directed by the website link) and email to screferrals@silverchain.org.au
Referral form link	https://www.silverchain.org.au/wa/referrers/refer-to-primary-care-at-home/
Cost	FREE
Contact phone	General enquires: 9242 0242

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MEN'S SHED

Men's Shed	
Service description	Men's Sheds are community-based, non-profit, non-commercial organisations that are accessible to all men where men are able to work on meaningful projects at their own pace in their own time in the company of other men. A major objective is to advance the well-being and health of their male members.
Website	AMSA Men's Shed
Location	Armadale Community Men's Shed Address: 2 Tudor Road Armadale 6112 Phone: 9497 3132 0428 408 137 Heart and Soul Men's Shed Address: Lot 800 Armadale Road Forrestdale 6112 Phone: 9397 2465 RGE Men's Shed Inc Address: 2462 Albany Hwy Gosnells Phone: 9398 8008 Gosnells Community Men's Shed Address: 70 Lissiman Street Gosnells Phone: 9388 4064 Serpentine Jarrahdale Community Shed Address: Lot 213 Baskerville Rd Mundijong 6123 Phone: 9525 9123

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MENTAL HEALTH AND COUNSELLING

PORTS (Practitioner Online Referral and Treatment Service)	
Relevant disciplines	• Psychologists • Psychiatrists • Mental health Nurse • GP Liaison
Relevant conditions	Symptoms of mild to moderate anxiety, depression or substance misuse that would benefit from a short-term intervention
Service description	Our services are designed to help GPs in primary mental health care. We aim to provide: • Easy and efficient referrals followed by patient contact within 1 - 3 business days • Expert mental health assessments and timely reporting to the referring GP • Regular GP consultation • Clinically effective treatments • Linkage to support services
Website	PORTS
Eligibility criteria	• At least 16 years of age and residing in Western Australia • Symptoms of mild to moderate anxiety, depression or substance misuse that would benefit from a short-term intervention • Are financially disadvantaged (eg. Health Care Card or unemployed)
Who can refer	General Practitioner, Allied Health Staff.
Referral method	• Printing a referral and sending a fax to 02 9475 0249 • Downloading a referral form from their practice software • Call PORTS on 1800 176 787 (1800 1 PORTS)
Referral form link	Referral form-PORTS
Other information	If the referral form is not on your practice software please download and complete this form
Cost	Free
Location	Service is delivered via telephone and/or online
Contact phone	Phone: 1800 176 787

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Derbarl Yerrigan Health Service (DYHS)	
Service description	Derbarl Yerrigan Maddington offer a range of visiting programs that include; • Maternal & Child Health • Chronic Disease Management • Aboriginal Liason Officer • Indigenous Outreach • Bringing them Home • Allied Health service. • Respiratory Clinic A range of other programs are also offered at alternate Derbarl Yerrigan clinics (East Perth, Midland and Mirabooka).
Relevant disciplines	• General Practitioners • Registered Nurses • Nurse Practitioner • Aboriginal Health Practitioner • Podiatrist • Respiratory Specialist
Eligibility criteria	• Aboriginal, Torres Strait Islander or Partner of an Aboriginal/TSI person (however not a requirement)
Referral method	Phone/Walk-in
Who can refer	Anyone – walk in service
Referral form link	N/A
Cost	All services are bulk billed to those who have a Medicare card
Location	Unit 1-2, Lot 5 Binley Place Maddington WA 6109
Contact phone	Phone: (08) 9452 5333 Fax: (08) 9452 5344
Website	www.dyhs.org.au/

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Dementia Australia	
Relevant conditions	Alzheimer's disease
Service description	Provides specialist services to people with dementia and their families/carers, including: • National Dementia Helpline • Carer's Support Groups • Carer Support and Information Program • Dementia Enavling Environments Project • Counselling • Education Workshops • Behaviour Management Advisory Service • Respite Options • Art Programmes.
Website	Dementia Australia
Eligibility criteria	N/A
Who can refer	Self-referral
Referral method	Phone: 9388 2800
Cost	Most services are free. Some may require a payment depending on the patient.
Location	55 Walters Drive, Osborne Park 6017
Contact phone	Osborne Park Head Office: 9388 2800 Dementia Helpline: 1800 100 500

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Carers Australia WA	
Service description	Provide the following services for anyone who is a carer for someone else, including young carers: • counselling • information and advice • education and training • Carer Wellness at Home Program • social support • Prepare to Care Hospital Program • Carer Representation Program • Young Carer's Program • better start for children with disability • working carers support • carers retreat
Website	Carers WA
Eligibility criteria	N/A
Who can refer	• self-referral/enrolment - health professionals can provide carer with Carers WA information pack • allied health • GP.
Referral method	Carers can self-refer by calling the number listed below otherwise health professionals can complete the form provided in the link below.
Referral form link	https://wa.healthpathways.org.au/357366.htm
Other information	Patient handouts are available to download at Digital Resources for Carers in Western Australia | Carers WA
Cost	Variable depending on program.
Location	182 Lord Street, Perth WA 6000
Contact phone	General Enquires: 1300 227 377 Carers Counselling Line: 1800 007 332 Advisory Line: 1300 227 377

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NEUROLOGICAL CONDITIONS

Motor Neurone Disease WA (MNDWA)	
Relevant conditions	Motor Neurone Disease
Service description	The Motor Neurone Disease Association of WA (MNDAWA) is committed to providing specialised care and support services for people living with MND, their carers and families in Western Australia. MNDWA provides care coordination and emotional support connecting those living with MND to the services that they require. MNDAWA also provides education and support groups**,** , equipment, and specialised funding**.** As part of our mission we advocate for people living with MND to ensure they receive the best possible care and services, as well as contributing to MND research to achieve our vision of living in a world free from MND.
Website	MND Western Australia
Eligibility criteria	Clients with Motor Neurone Disease, their families or carers
Who can refer	• Self-referral • GP • Other health professionals
Referral method	Call or email to find out more about how to access services through MNDWA
Location	The Niche B/11 Aberdare Road NEDLANDS 6009
Contact phone	Phone: 6457 7355 Email: admin@mndawa.asn.au

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Multiple Sclerosis of WA (MSWA)	
Relevant conditions	All neurological conditions
Service description	MSWA provides vital support and services to people living with neurological conditions in Western Australia. This includes people living with multiple sclerosis, stroke, Parkinson's Disease, Huntington's Disease, Motor Neurone Disease, and acquired Brain Injury, to name a few. MSWA is a non-government, not-for-profit organisation. The money we raise through our fundraising efforts, government grants and other income generating programs goes directly to providing a range of supports and services to people living with MS, and other neurological conditions. Our team of experienced nursing and allied health professionals provide information and a range of supports from the time of diagnosis.
Website	MSWA
Eligibility criteria	All people with a neurological condition
Who can refer	• Self-referral • GP • Other health professionals
Referral method	Please complete the online referral form or alternatively you can call the number below for assistance.
Other information	Membership is $20 per year per client and enables access to a number of support services. MSWA is also a registered NDIS service provider- for NDIS support please call 1800 287 367
Location	29 Parkhill Way Wilson WA 6107
Contact phone	Phone: 9365 4888 Country callers: 1800 287 367

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Neurological Council of WA	
Relevant conditions	All neurological conditions
Service description	The Neurological Council of WA is an umbrella organisation to several neurological, condition-specific and associated organisations who share its vision of working together for awareness, coordinated and improved services for people with neurological conditions. The Neurological Council of WA provides a Community neurological nursing service called **Neurocare** to support all people living with the impact of a Neurological condition. Clients can access Neurocare at any time they feel the need for support, including pre-diagnosis, diagnosis and post diagnosis.
Website	Neurological Council of WA
Eligibility criteria	All people with a neurological condition
Who can refer	• Self-referral • GP • Neurologist • Other health professionals
Referral method	Fax completed referral form to 9346 7534 or scan document cc2@ncwa.com.au
Referral form link	Neurological Council of WA
Other information	N/A
Cost	Will be calculated individually. Please complete referral form and a member of the team will contact the client to discuss options.
Location	Neurocare is offered in the patient's home. The service is offered in Perth Metro, Great southern, Mid-west and the South West.
Contact phone	Phone: 1800 645 771

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Parkinson's WA	
Relevant conditions	Parkinson's disease
Service description	Parkinson's Western Australia Inc. provides a Parkinson's Nurse Specialist Service, support networks for people with Parkinson's and their family and carers and educational resources and training. Services offered include; • Parkinson's nurse specialists • Seminars • Support groups • Support programs (includes Dance for Parkinson's, Park yoga, Parkin Song and Tai Chi)
Website	Parkinson's WA
Eligibility criteria	Clients with Parkinson's Disease, their families or carers
Who can refer	• Self-referral • Any health professional
Referral method	See website for details as to how to contact or alternatively call the number below for assistance
Cost	Membership starts from $36 per year. For more information regarding membership see Parkinson's WA Membership
Location	Support groups and programs are offered at various locations around the Perth metro area The Parkinson's nurse specialist can visit a patient in their home as required.
Contact phone	Phone: (08) 6457 7373 Email: info@parkinsonswa.org.au

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PALLIATIVE CARE

Bethesda Metropolitan Palliative Care Consultancy Service	
Service description	Bethesda Health Care's Metropolitan Palliative Care Consultancy Service (MPaCCS) is a mobile specialist palliative care team, focusing on capacity building of the palliative care sector workforce through training, education, assistance and mentoring where there are currently no specialist palliative care consultation services available for residents or patients at the following locations: • mental health and psycho-geriatric facilities • residential aged care facilities • residential disability facilities • correctional facilities • Aboriginal and Torres Strait Islander medical service facilities • General Practitioners (GPs) and consultants working in the above facilities • hospital staff engaged in the discharge planning for patients who will transfer to a facility or institution.
Website	Bethesda – MPaCCS
Eligibility criteria	N/A
Who can refer	• Medical professionals • Hospital staff
Referral method	Fax completed referral form to 9217 1777 and an MPaCCS nurse will call to triage the referral appropriately.
Referral form link	Bethesda – MPaCCS
Other information	N/A
Cost	Free of charge or contribution towards the cost.
Contact phone	Phone: 9217 1777 Fax: 9217 1788 Email: MPaCCS@bethesda.org.au

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Silver Chain Palliative Care	
Service description	Palliative care is provided for individuals with a life limiting illness or condition. As a community-based service, we specialise in supporting people and families with complex needs to remain at home. Each person's experience is unique, so care is taken to address the emotional distress caused by the consequences of the diagnosis and disease as well as the practical issues around finances, accommodation and social support, where needed. Our palliative care teams consist of nurses, doctors, care aides, social workers, counsellors and chaplains.
Website	Silver Chain – Palliative Care
Eligibility criteria	Client must have an active, progressive, terminal illness that requires symptom management. If in doubt please call the Hospice Liaison Nurse on 0410 222 055.
Who can refer	Medical professionals (community or hospital).
Referral method	Fax completed referral form to 9444 7265.
Cost	Free of charge or contribution towards the cost.
Contact phone	General enquires: 9242 0242

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PODIATRY

ABORIGINAL HEALTHY LIFESTYLE PROGRAMS (EMHS): Moorditj Djena (Strong Feet)	
Service description	Moorditj Djena (Strong Feet) – Moorditj Djena is a podiatry and diabetes education outreach program for Aboriginal people within the Perth metropolitan area. Culturally appropriate podiatry and diabetes education for Aboriginal people is provided with a focus on prevention and management of foot complications and their risk factors such as diabetes, peripheral arterial disease, peripheral neuropathy and other chronic diseases. Services include: • Podiatry for assessment, treatment and education of all foot related concerns. This covers wound care, nail surgery, biomechanical assessment and orthotic provision. Education is also given regards choosing the correct footwear and how to look after your feet. • Aboriginal Health Workers for health interventions for prevention methods, health education, support and advocacy. • Dietitian to discuss healthy eating for diabetes and other chronic conditions, including ideas for shopping on a budget, cooking healthier meals and providing recipes. • Diabetes Educator to help clients self-manage their diabetes effectively and prevent complications.
Relevant conditions	• Diabetes • Vascular Disease, • Neuropathy • Obesity • Foot Deformity • Ulceration • Chronic foot problems
Eligibility criteria	• Aboriginal, Torres Strait Islander or Partner of an Aboriginal/ Torres Strait Islander person • ≥18 years old
Location	Multiple locations. Mobile vans that service the northern, southern and eastern metropolitan areas of Perth. Call for details.
Who can refer	Patients can self-refer. Health professionals can provide referrals/handovers for collateral information (GP, Allied Health Staff and Nurses).
Referral method	Walk-in appointments, or contact/book through phone, fax or email.
Contact Details	Phone: (08) 9278 9922 Fax: (08) 9250 1419 Email: moorditjdjena@health.wa.gov.au
Cost	Free
Website	https://emhs.health.wa.gov.au/Hospitals-and-Services/Aboriginal-Health/Moorditj-Djena
Resources	Program Brochure

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Derbarl Yerrigan Health Service (DYHS)	
Service description	Derbarl Yerrigan Maddington offer a range of visiting programs that include; • Maternal & Child Health • Chronic Disease Management • Aboriginal Liason Officer • Indigenous Outreach • Bringing them Home • Allied Health service. • Respiratory Clinic A range of other programs are also offered at alternate Derbarl Yerrigan clinics (East Perth, Midland and Mirabooka).
Relevant disciplines	• General Practitioners • Registered Nurses • Nurse Practitioner • Aboriginal Health Practitioner • Podiatrist • Respiratory Specialist
Eligibility criteria	• Aboriginal, Torres Strait Islander or Partner of an Aboriginal/TSI person (however not a requirement)
Referral method	Phone/Walk-in
Who can refer	Anyone – walk in service
Referral form link	N/A
Cost	All services are bulk billed to those who have a Medicare card
Location	Unit 1-2, Lot 5 Binley Place Maddington WA 6109
Contact phone	Phone: (08) 9452 5333 Fax: (08) 9452 5344
Website	www.dyhs.org.au/

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Armadale Health Service Podiatry Outpatients	
Relevant disciplines	Podiatry
Relevant conditions	• type 1 diabetes • type 2 diabetes • rheumatoid arthritis • peripheral vascular disease • previous history of amputation.
Website	N/A
Eligibility criteria	Adult patients with sub-acute foot condition such as minor wounds, previous ulceration and/or amputations and chronic charcot neuro arthropathy.
Who can refer	• allied health • GP • nurse
Referral method	Fax a letter outlining the request to: 9391 2229 OR Post: Armadale Community Health PO Box 460 Armadale WA 6996
Referral form link	N/A
Other information	Ongoing care for simple nail cutting, warts and corns should be referred to Private podiatrist under MBS Team Care Arrangement (TCA) or GP Chronic Health Management Plan. Podiatry only provides insoles for patients with previous foot ulceration, amputation and / or chronic charcot neuroarthropathy.
Cost	Free.
Location	G1 Gallier General Outpatient, Armadale Health Service 3056 Albany Highway, Armadale
Contact phone	9391 1118

For a comprehensive directory of podiatrist please visit the National Health Services Directory. These services can be accessed through a GP Management Plan.

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RESIDENTIAL AGED CARE SERVICES

Silver Chain - Home Hospital	
Service description	Provides patients with hospital-level care in their own home. Service provided by medical practitioners, nurse practitioners and nurses who provide high-level acute care, normally provided in a hospital or ED. See website for list of common treatments.
Website	Silver Chain – Home Hospital
Eligibility criteria	Patients must: • be living at home or in a residential care facility • require short term acute and sub-acute care that can be delivered safely in the home • not require an emergency response and be safe to wait up to four hours • be aged 13 and over • be no more than 22 weeks pregnant • be able to communicate effectively, directly or through an interpreter • be medically and mentally stable • be Medicare eligible • have given their consent.
Who can refer	• GP • specialist • community nurse • health direct • residential aged care facility (RACF) • hospital staff • ED
Referral method	Fax referral form and ALN will call to discuss referral Fax: 9444 7265
Referral form link	Home Hospital
Other information	N/A
Cost	Free or contribution towards the cost.
Location	Service provided in patients home.
Contact phone	Ph: 1300 466 346

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Silver Chain Priority Response Assessment	
Service description	Priority Response Assessment: 24/7 assessment service that provides advanced clinical assessment in patients home or residential care facility within a four hour response period, therefore avoiding Emergency Department attendance.
Website	Silver Chain – PRA
Eligibility criteria	Patients must: • be living at home or in a residential care facility • require short term acute and sub-acute care that can be delivered safely in the home • not require an emergency response and be safe to wait up to four hours • be aged 13 and over • be no more than 22 weeks pregnant • be able to communicate effectively, directly or through an interpreter • be medically and mentally stable • be Medicare eligible • have given their consent. • If patient has COPD, patient requires COPD management plan
Who can refer	• GP • specialist • medical hospital staff • residential aged care facility (RACF)
Referral method	Phone: 1300 466 346 to speak with Ambulatory Liaison Nurses.
Referral form link	N/A
Other information	N/A
Cost	Free
Location	Service provided in patients home.
Contact phone	1300 466 346

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Bethesda Metropolitan Palliative Care Consultancy Service	
Service description	Bethesda Health Care's Metropolitan Palliative Care Consultancy Service (MPaCCS) is a mobile specialist palliative care team, focusing on capacity building of the palliative care sector workforce through training, education, assistance and mentoring where there are currently no specialist palliative care consultation services available for residents or patients at the following locations: • mental health and psycho-geriatric facilities • residential aged care facilities • residential disability facilities • correctional facilities • Aboriginal and Torres Strait Islander medical service facilities • General Practitioners (GPs) and consultants working in the above facilities • hospital staff engaged in the discharge planning for patients who will transfer to a facility or institution.
Website	Bethesda – MPaCCS
Eligibility criteria	N/A
Who can refer	• Medical professionals • Hospital staff
Referral method	Fax completed referral form to 9217 1777 and an MPaCCS nurse will call to triage the referral appropriately.
Referral form link	Bethesda – MPaCCS
Other information	N/A
Cost	Free of charge or contribution towards the cost.
Contact phone	Phone: 9217 1777 Fax: 9217 1788 Email: MPaCCS@bethesda.org.au

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SENIORS CLUBS

Seniors Clubs	
Service description	Activities such as indoor bowls, book clubs, day outings, podiatry services and computer classes are offered.
Cost	Varies dependant on activity
Location	Roleystone-Karragullen Seniors Club Address: Jarrah Road Roleystone Ph: 9390 6114 Website: City of Armadale – Seniors Westfield Kelmscott Seniors Club Address: Harold King Centre Phone: 9390 5204 Website: City of Armadale – Seniors Books on Wheels Address: Seville Grove Library Phone: 9399 9511 Website: City of Armadale – Seniors Addie Mills Centre Address: 2 Astley Street, Gosnells Phone: 9391 6030 Website: Addie Mills

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SERVICES IN THE HOME/ASSESSMENT FOR RESIDENTIAL CARE

Aged Care Assessment Team (ACAT)

	The Aged Care Assessment Team (ACAT) is a specialist multi-disciplinary team providing comprehensive assessments to frail older people and younger people with high or complex needs. Assessments are provided both in the community and in Hospital.
Service description	The Armadale ACAT comprises a team of Social Workers and Nurses, with additional support from the Geriatric team (as required). Referrals are considered for clients requiring assessment of their eligibility to access Commonwealth funded aged care services, residential respite care and permanent residential care.
Website	My Aged Care
Eligibility criteria	• medically stable • target population are frail aged population aged ≥ 65 years or ≥ 50 years for Aboriginal or Torres Strait Islander people • ACAT will consider referrals for assessment of younger people if there are no other care facilities or services more appropriate to the person's needs. If a patient is functioning well and only limited assistance is required, refer to HACC services instead.
Who can refer	ACAT will accept referrals from any source; however a GP referral is the preferred method.
Referral method	Please fax a completed referral form to 9391 2262
Referral form link	N/A
Cost	Free.
Contact phone	1800 200 422

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Aged Care Guide

Service description	A website providing comprehensive information on the availability of aged care packages and residential care and retirement village vacancies. Contains a directory that allows you to search by location, provider or vacancy. A printed directory of all public and private nursing homes, low care facilities, community care and retirement living options can be ordered from the website.
Website	Aged Care Guide
Eligibility criteria	Individual criteria to accessing services will apply. Visit the website for more information on ACAT and RAS assessments and how to access assistance in the home or residential care.
Cost	Free

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Home and Community Care Services (HACC)

Service description	Long term subsidised services including personal care, social support, domestic assistance, medication prompts, and transport assistance.
Website	https://wa.healthpathways.org.au/52382.htm
Eligibility criteria	• older and frail and having difficulty with everyday tasks, including accessing their local community • patients with a disability that impacts on their ability to undertake everyday tasks • carers of these patients.
Who can refer	• allied health • self-referral • relative referral
Referral method	Phone Regional Assessment Service: 1300 785 415
Cost	Fees are determined by the service provider, and are based on type of services and income assessment. Patients will be advised of cost by the service provider. If patients cannot afford fees they can discuss fee reduction options with the service provider. No one will be denied support because they cannot afford to pay fees.
Location	N/A
Contact phone	1300 785 415

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SMOKING CESSATION AND SUPPORT

Quitline	
Service description	Quitline is a telephone information and advice or counselling service for people who want to quit smoking. You can phone the Quitline confidentially from anywhere in Australia for the cost of a local call.
Website	Quitline
Eligibility criteria	N/A
Who can refer	• Self-referral • Any health professional
Referral method	Individual can phone the service independently or a health professional can complete the below form and fax to 8291 4280
Referral form link	Quitline Referral form
Other information	Patients can order a free Quit packs over the phone
Cost	Free
Location	Phone service
Contact phone	Phone: 13 78 48

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Quitline Aboriginal Liaison Team (QALT)	
Service description	The QALT Project Officers focus on promoting the Quitline and providing information about the Quitline service to primary health care services who work with Aboriginal and Torres Strait Islander people in Western Australia (WA) to support and promote Quitline referrals and overall reducing the prevalence and incidence of smoking rates within WA. Our primary focus is to support the non-Tackling Indigenous Smoking (TIS) recipients in the South West & Great Southern regions although we do provide support across state – wide of Western Australia how are we doing this? • Continually provide support to health services who engage with Aboriginal and Torres Strait Islander people to Quitline • Support the regional & remote TIS teams across WA • Working in collaboration with key stakeholders i.e. Australian Council Of Smoking Health (ACOSH) , Cancer Council Western Australia (CCWA), Cancer Council South Australia (CCSA) • Attend metro, regional and remote community events promoting the Quitline • Distribution of QALT resources to local AMS's and hospitals within WA • Creating and redeveloping new culturally safe and relevant resources • Promote, organise and support Quitskills three day nationally recognised training on smoking cessation • Deliver a component on Day 3 of the Quitskills training – promoting the Quitline • Provide 1 day free Brief Intervention Training session
Website	https://www.ahcwa.org.au/qalt
Who can refer	• The patient can self-refer by calling 13 78 48 • Allied health, nursing and medical professionals can refer online or via email.
Referral method	Referrals can be submitted by completing the referral form and sending via email, or by completing the online referral form on the Quitline website.
Referral form link	https://www.cancersa.org.au/health-professionals/referrals/
Other information	• Opening Hours: Monday – Friday 8am to 8pm & Saturday 12:30pm to 3:30pm • Once referral is received they will contact you within 24hrs • The cost of the call is the same as a standard phone call, if needed they will call you back to save money • Aboriginal Counsellors are available • Use of interpreter service available if required • Provide support to individuals, families or groups wanting to cut down or quit • Discuss Nicotine Replacement therapy options and availability • Able to link people to services within local areas • Service available for up to 3 months, can be longer if the client needs.
Cost	FREE

Contact phone	(08) 9227 1631 Monday – Friday 8am to 8pm Saturday 12:30pm to 3:30pm
Email address	galt@ahcwa.org

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SUPPORT GROUPS

Connect Groups	
Service description	Connect Groups aims to help people help each other by providing Self Help and Support Groups with: • Links to community networks and information. • Assistance with group development and management. • Support with community resources and services. • Individual and group skills training. Directory of Support groups and services
Website	Connect Groups
Contact phone	Phone: 9364 6909

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SUB-ACUTE REHABILITATION

Armadale Health Service Community Rehabilitation	
Relevant disciplines	Allied health, medical and nursing
Service description	Community Rehabilitation delivers outpatient subacute care to people living in the community. This multidisciplinary service provides adult clients with a comprehensive assessment and rehabilitation service to regain or retain certain physical or cognitive function. The Community Rehabilitation team consists of: • Clinical Psychologist • Dietitian • Falls specialist coordinators • Geriatricians • Nurse • Occupational Therapist • Physiotherapist • Rehabilitation physician • Social Worker • Speech Pathologist • Therapy Assistant Please note there may be wait times for appointments.
Website	Community Rehabilitation
Eligibility criteria	• aged 18+ • reside in the Armadale Health Service catchment • be medically stable and safe for hospital discharge • has a GP willing to provide medical support (clients without a usual GP will be assisted to access GP services and geriatrician/rehabilitation physician support will be provided if indicated) • willing to engage in treatment
Who can refer	• GP • hospital staff
Referral method	Referrals to see a community rehabilitation doctor must be sent through to the Central Referral System. All other referrals – Fax: 9391 2262.

Other information	Make sure to highlight on the referral: • If a patient's Next of Kin needs to be informed of appointments as well as the patient • If a patient needs an interpreter • If there is a tricky social situation Make sure to include the patient's GP details. Please send **one** referral form with all disciplines required filled in. Make sure to tick the professions required. Triage Officer is always happy to discuss referrals and services available.
Cost	Free
Location	Armadale Health Service Can also be delivered at the client's home, or at community venues suitable to clients/service needs.
Contact phone	9391 2512

For a comprehensive directory of allied health services please visit the National Health Services Directory. These services can be accessed through a GP Management Plan.

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Curtin University Cockburn Clinic	
Relevant conditions	Sub-acute rehabilitation
Service description	A free student led inter-professional service across a range of disciplines. The clinic aims to meet your functional goals by helping you maintain quality of life, participate in daily activities, return to work or meaningful occupational activities and be active in the community. Adult services are available to people 16 years old and over living in the Perth metropolitan area, with priority given to local Cockburn residents. We address health conditions including, but not limited to: • **neurological conditions** such as stroke, Parkinson's disease or multiple sclerosis • **orthopaedic conditions** such as rheumatoid arthritis or joint replacements • **chronic diseases** such as diabetes and obesity • **musculoskeletal conditions** such as chronic pain • **dementia and memory** difficulties • **mobility** difficulties or risk of falls • **communication or swallowing** difficulties • **mental health conditions** such as anxiety, depression, post-traumatic stress disorder, stress and bullying, relationship difficulties, gender diversity, and chronic pain.
Website	Curtin University – Cockburn Clinic
Eligibility criteria	16 years or over
Who can refer	• GP • allied health • self-referral (except counselling psychology services)
Referral method	Via referral form below.
Referral form link	Curtin University – Cockburn Clinic/Referral form
Cost	Free.
Location	Cockburn Integrated Health Level 1, 11 Wentworth Parade, Success
Contact phone	9494 3751

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Rehabilitation In The Home (RITH)	
Service description	Rehabilitation in the Home (RITH) provides short to medium term hospital substitution allied health therapy for patients at home. The service aims to facilitate early supported discharge from hospitals or avoidance of hospital admission for patients.
Relevant Disciplines	• Physiotherapy • Occupational Therapy • Speech Pathology • Dietetics
Eligibility criteria	To be eligible for RITH, the patient must: • require allied health services which would require hospitalisation and cannot be provided in an outpatient clinic or community setting • be medically stable • have adequate home support • have an accessible and safe home environment • be able to actively participate in goal orientated rehab program • consent to allied health service at home • live in the Perth metropolitan area Patients are NOT eligible to receive the RITH service if they: • receive, or are able to receive, or should receive therapy in an outpatient setting • require one-off visits for equipment or provision of home-based services • are referred to Silver Chain Personal Enablement Program • may place staff at an unreasonable risk of harm • reside in a prison • are referred directly from a GP • reside in a residential care facility/require maintenance therapy
Who can refer	Hospital allied health staff.
Referral method	**Referral Process** Contact the relevant RITH site's Intake Therapist / Coordinator to discuss the referral BEFORE the patient is discharged from the hospital. See contact details. 9. Complete the RITH referral form 10. Ensure RITH consent section is signed by the patient, including the separate RITH Contract when indicated. 11. Ensure the Risk Identification section is completed. 12. Send the completed forms and all other relevant handover information to RITH via fax / email. Refer to contact details. **After Hours Referrals** RITH accepts referrals to from 8am to 9pm on weekdays and 8:30am to 5pm on weekends. To make a referral after hours; 9. Contact the RITH on call referral service via RPH Switchboard at 9224 2244. 10. Discuss the referral with the on call RITH staff. 11. If the referral is accepted, complete RITH referral and all other relevant forms/handover indicated (as above) 12. Send the completed documentation to the relevant RITH

	sites via fax / email. Refer to contact details.
Referral form link	Rehabilitation in the Home/Referral Form (only accessible to hospital staff)
Cost	Free
Location	Service is provided in the client's home.
Contact phone	6477 5151 After hours – 9224 2244

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Silver Chain- Hospital Discharge Support (HDS)	
Service description	Hospital Discharge Support is rapid response service which provides support to you in the community. It will help you recover from a recent illness or surgery. Our allied health team will assess you in your home and design a short-term program around your own goals. The length of time you will spend in the program depends on your individual needs. Our aim is to get you back on your feet and help you avoid a return to hospital. HDS is an Allied Health led, evidence based, reablement service for clients coming out of hospital. HDS aims to support the successful discharge of clients and prevent unnecessary readmission. HDS includes setting up the home environment successfully for the client, falls prevention and reablement towards activities the person was doing prior to their hospital stay. The program goals, types of supports, services and frequency of visits are determined by the Silver Chain Allied Health Professional in conjunction with the client following assessment. HDS Services are delivered between 7am-5pm, Monday to Friday.
Relevant Disciplines	• Physiotherapy • Occupational Therapy
Eligibility criteria	Patient's must: • Be in hospital at the time of the referral • Be medically stable • Reside in an area where Hospital Discharge Support is available. • Patient must have a functional need which requires Personal Care as part of the service (Previous HACC eligibility will be applied) Not Eligible: • Private patients in private hospitals • Patients with NDIS funding • Patients in receipt of a Home Care Package (they may be able to receive an HDS service funded through their package and should check with their provider if this is possible), or they may be able to access Allied Health Reablement services via CHSP • Clients awaiting a Home Care Package (they may be able to access Allied Health Restorative Care Services through CHSP). They can be referred to My Aged Care. • HDS is available to eligible clients for up to 6 weeks. HDS clients may be referred to other services where their needs exceed a 6-week service.
Who can refer	• Medical • Allied Health • Nursing
Website	Silver Chain – Hospital Discharge Support
Referral method	Weekdays: between 8:30am and 4:30pmreferrals can be made to Allied Health Liaison via phone (9242 0347). Be prepared to

	answer questions relating to the patient by way of a phone screening. After hours: between 4:30pm and 11pm weekdays, weekends and public holidays referrals can be made to ALN's from ED or equivalent only via phone (9242 0347). A phone screening tool is used.
Cost	FREE
Contact phone	Allied Health Liaison 9242 0347

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VISION IMPAIRMENT

Visibility (Formerly Association for the Blind)	
Relevant conditions	Vision impairment
Service description	Assist health professionals with: • low vision assessments • acquired brain injury • professional development • can organise joint home visit with OT. Individual/family support with: • employment • independent living (specific aids and equipment) • health and wellbeing • training courses • library services • assistive technology • therapy services.
Website	https://www.visability.com.au/
Eligibility criteria	N/A
Who can refer	• allied health • GP • self-referral
Referral method	Phone: 1800 847 466 Email: info@visability.com.au
Cost	Free
Location	The Perron Centre, 61 Kitchener Avenue, Victoria Park 6979
Contact phone	1800 847 466 or 9311 8202

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WEIGHT MANAGEMENT

Arche Health - Active Measures	
Service description	Active Measures is a weight management program operating at our Bentley office to service the ongoing chronic disease needs of the community: • one-on-one sessions with an Accredited Exercise Physiologist • one-on-one appointments with an Accredited Practising Dietitian • group education sessions run by an Accredited Practising Dietitian.
Website	Arche Health – Active Measures
Eligibility criteria	Over 18 years old
Who can refer	• allied health • GP • hospital • self-referral
Referral method	Fax completed referral form to: 9458 0555 Email: activemeasures@archehealth.com.au Please refer to the website for additional requirements for those Medicare – eligible patients with a GPMP
Referral form link	N/A
Other information	Group nutrition education sessions are run for all members of the community and a referral is not required. Please refer to website for details.
Location	Unit 4/1140 Albany Highway, Bentley 6102
Contact phone	9458 0596

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Last review date : 31st March 2021

Armadale Health service acknowledges WA Primary Health Alliance (WAPHA) for providing funding in its role as the operator of the Perth South PHN.