



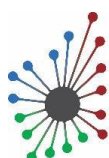
## Armadale Kalamunda Group referral database

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](mailto:AHS.CareCoordination@health.wa.gov.au).

- **Aboriginal Health**
  - East Metropolitan Health Service (EMHS) Aboriginal Health Unit
    - [Moorditj Djena- Podiatry & Diabetes \(Strong Feet\)](#)
    - [LIFE Program \(Living Improvements for Everyone\)](#)
    - [I'm Moordidjabinj \(Becoming Strong\) Program](#)
    - [The Journey of Living with Diabetes Program](#)
  - Arche Health
    - [Wangen Murduin Integrated Team Care Chronic Disease Program](#)
  - [Derbarl Yerrigan Health Service](#)
- **Anxiety management**
  - [PORTS](#)
- **Arthritis**
  - [LIFE Program \(Living Improvements for Everyone\)- EMHS Aboriginal Health Unit](#)
  - [Arthritis and Osteoporosis WA](#)
- **Asthma**
  - [Asthma Educational Individualised Sessions](#)
- **Carers WA**
  - [Carers Australia WA](#)
- **Case Coordination**
  - [Complex Needs Coordination Team \(CoNeCT\)](#)
  - [Arche Health- Wangen Murduin Integrated Team Care Chronic Disease Program](#)
- **Chronic lung condition**
  - [360 Health + Community – Healthy Lifestyle Program \(HLP\)](#)
  - [Armadale Health Service – Pulmonary Rehabilitation](#)
  - [Lung Foundation](#)



- [LIFE Program \(Living Improvements for Everyone\)- EMHS Aboriginal Health Unit](#)
- [Silver Chain – Respiratory Care](#)
- **Chronic heart condition**
  - [360 Health + Community – Healthy Lifestyle Program \(HLP\)](#)
  - [Armadale Health Service – Cardiac Rehabilitation](#)
  - [Curtin University Health and Wellness Clinic](#)
  - [Heart Foundation](#)
  - [LIFE Program \(Living Improvements for Everyone\)- EMHS Aboriginal Health Unit](#)
- **Chronic pain management**
  - [LIFE Program \(Living Improvements for Everyone\)- EMHS Aboriginal Health Unit](#)
  - [Arche Health – Community Pain Management Service](#)
- **Continence assistance**
  - [Bladder and Bowel Health Australia](#)
- **Diabetes management**
  - [The Journey of Living with Diabetes Program- EMHS Aboriginal Health Unit](#)
  - 360 Health + Community
    - [DESMOND](#)
    - [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](#)
  - [Curtin University Health and Wellness Clinic](#)
  - Diabetes WA
    - [Diabetes WA Information and Advice Line \(DIAL\)](#)
  - [Private Credentialed Diabetes Educators](#)
- **Dietetic services**
  - [Armadale Health Service – Nutrition and Dietetics Outpatients](#)
  - [360 Health + Community – Dietetics](#)
- **Equipment needs**
  - [Independent Living Centre](#)
- **Exercise groups**
  - [I'm Moordidjabinj \(Becoming Strong\) Program- EMHS Aboriginal Health Unit](#)
  - [Local exercise groups](#)
- **Exercise physiologists**
  - [Living Longer Living Stronger](#)
  - [360 Health + Community – Exercise Physiology](#)



- **Hospital Avoidance**
  - [Silver Chain – Home Hospital](#)
  - [Silver Chain – Priority Response Assessment](#)
- **Memory impairment**
  - [Alzheimer's Australia WA](#)
  - [Dementia Behaviour Management Advisory Service \(DBMAS\)](#)
- **[Men's Shed](#)**
- **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](#)
- **Physiotherapy services**
  - [Community Physiotherapy Service](#)
  - [Silver Chain – Physiotherapy](#)
- **Podiatry**
  - [Moorditj Djena- Podiatry & Diabetes \(Strong feet\)- EMHS Aboriginal Health Unit](#)
  - [360 Health + Community – Podiatry](#)
  - [Armadale Health Service – Podiatry Outpatients](#)
- **[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](#)**
- **[Support Groups](#)**
- **Sub-acute rehabilitation**
  - [Armadale Health Service – Community Rehabilitation](#)
  - [Curtin University – Cockburn Clinic](#)
  - [Rehabilitation in the Home \(RITH\)](#)
  - Silver Chain



- [Home Independence Program \(HIP\)](#)
- [Personal Enablement Program \(PEP\)](#)
  
- **Vision impairment**
  - [VisAbility \(formerly Association for the Blind\)](#)
  
- **Weight management**
  - [Arche Health – Active Measures](#)
  - [Diabetes WA- SHED-IT](#)



## East Metropolitan Health Service- Aboriginal Healthy Lifestyle Programs Moorditj Djena- Podiatry & Diabetes (Strong Feet)

**Relevant disciplines**

- Podiatrist
- Aboriginal Health worker
- Dietitian
- Diabetes Educator

**Relevant conditions**

- Diabetes
- Vascular Disease,
- Neuropathy
- Obesity
- Foot Deformity
- Ulceration
- Chronic foot problems

**Service description**

Podiatrists - Assess your feet (Djena) for problems, check blood flow, sensation and provide required treatment. All aspects of Podiatry are covered including 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 – Provide health checks, including blood pressure, blood glucose levels, health education and cultural support.

Dietitian – Talk about healthy eating for chronic diseases, ideas for low cost meals and help with recipes to reduce fat, sugar and salt

Diabetes Educator – Help control blood sugar levels, check medications and assist with insulin management

**Eligibility criteria**

- Aboriginal, Torres Strait Islander or Partner of an Aboriginal/TSI person
- ≥18 years old

**Who can refer**

Anyone – walk in service although referrals from GP, Care Coordinators, Nurses etc help with gathering critical health information

**Referral method**

Fax/Phone/Walk-in

**Referral form link**

N/A

**Cost**

Free Service

**Location**

Multiple locations. Call for details

**Contact phone**

Phone: (08) 9278 9922  
Fax: (08) 9250 1419

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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

[Program Brochure](#)


**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

**Referral method**

**Referral form link**

  
EMHS Aboriginal  
Healthy Lifestyle Proc

**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](mailto:EMHS.HealthyLifeStylePrograms@health.wa.gov.au).  
Ph: 9224 3778 / 9224 3749

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## East Metropolitan Health Service- Aboriginal Healthy Lifestyle Programs I'm Moordidjabinj (Becoming Strong) Program

**Relevant conditions** N/A

**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

[Program Brochure](#)

**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

**Referral method**

**Referral form link**



EMHS Aboriginal  
Healthy Lifestyle Proc

**Other information** The program is a 6 week program

**Cost** Free

**Location** Multiple locations

**Contact phone** Email: [EMHS.HealthyLifeStylePrograms@health.wa.gov.au](mailto:EMHS.HealthyLifeStylePrograms@health.wa.gov.au).  
Ph: 9224 3778 / 9224 3749

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## East Metropolitan Health Service- Aboriginal Healthy Lifestyle Programs 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

[Program Brochure](#)

**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**

- GP/Health professional
- Self-referral (however requires doctors clearance)

**Referral method**

**Referral form link**



JLWD & PDC Referral  
Form\_EMHS.pdf

**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

**Contact phone**

Email: [EMHS.HealthyLifeStylePrograms@health.wa.gov.au](mailto:EMHS.HealthyLifeStylePrograms@health.wa.gov.au)  
Ph: 9224 1981

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## Arche Health Wangen Murduin Integrated Team Care (ITC) Chronic Disease Program





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;

**Service description**

- 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

**Website**

[Arche Health Aboriginal Health Wangen Murduin ITC Brochure](#)

**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](mailto:aht@archehealth.com.au)

**Referral form link**

[Referral form](#)  
[Consent form](#)

**Cost**

Free

**Location**

N/A

**Contact phone**

Phone: (08) 9458 0505  
Fax: (08) 9458 8733

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**Derbarl Yerrigan Health Service**



<b>Relevant disciplines</b>	<ul style="list-style-type: none"> <li>• General Practitioners</li> <li>• Registered Nurses</li> <li>• Nurse Practitioner</li> <li>• Aboriginal Health Practitioner</li> <li>• Podiatrist</li> </ul>
<b>Service description</b>	<p>Derbarl Yerrigan Maddington offer a range of visiting programs that include;</p> <ul style="list-style-type: none"> <li>• Maternal &amp; Child Health</li> <li>• Chronic Disease Management</li> <li>• Aboriginal Liason Officer</li> <li>• Indigenous Outreach</li> <li>• Bringing them Home</li> <li>• Allied Health service.</li> </ul> <p>A range of other programs are also offered at alternate Derbarl Yerrigan clinics.</p>
<b>Website</b>	<a href="#">Derbarl Yerrigan Health Service</a>
<b>Eligibility criteria</b>	<ul style="list-style-type: none"> <li>• Aboriginal, Torres Strait Islander or Partner of an Aboriginal/TSI person (however not a requirement)</li> </ul>

**Who can refer**                      Anyone – walk in service

**Referral method**                      Phone/Walk-in

**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

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## 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**

[www.ports.org.au](http://www.ports.org.au)

**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**

- GP

**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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## 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

[Program Brochure](#)


**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

**Referral method** Please complete and email the form below

**Referral form link**



EMHS Aboriginal  
Healthy Lifestyle Proc

**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](mailto:EMHS.HealthyLifeStylePrograms@health.wa.gov.au).  
Ph: 9224 3778 / 9224 3749

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## Arthritis & 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** <https://www.arthritiswa.org.au/>

**Eligibility criteria** N/A

**Who can refer** Self-enrolment.

**Referral method** Information or enrolment:  
Phone: 9388 2199  
Email: [general@arthritiswa.org.au](mailto:general@arthritiswa.org.au)

**Referral form link** N/A

**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

**Contact phone** 9388 2199

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## Asthma Educational Individualised Sessions

**Relevant conditions** Patients 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

**Website** [Asthma Australia/Education Sessions](#)

**Eligibility criteria** N/A

**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** [Asthma Australia/Education Sessions/Referral](#)

**Other information** N/A

**Cost** Free

**Location** Armadale Community & Development Centre  
3056 Albany Hwy, Armadale WA 6112

**Contact phone** 9289 3600

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## Carers Australia WA

Provide the following services for anyone who is a carer for someone else, including young carers:

- Service description**
- 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 <https://www.carerswa.asn.au/publications/>

**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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## 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

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;

### Service description

- 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](mailto:aht@archehealth.com.au)

### Referral form link

[Referral form](#)  
[Consent form](#)

### Cost

Free

### Location

N/A

### Contact phone

Phone: (08) 9458 0505  
Fax: (08) 9458 8733

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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 + 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** Access to HLP 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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## 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 at AHS](#)

**Eligibility criteria** Refer to [https://wa.healthpathways.org.au/11652\\_1.htm](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/11652\\_1.htm](https://wa.healthpathways.org.au/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** [Lung Foundation](#)

**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** 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

[Program Brochure](#)

### 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

### Referral method

### Referral form link



EMHS Aboriginal  
Healthy Lifestyle Proc

### 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](mailto:EMHS.HealthyLifeStylePrograms@health.wa.gov.au).  
Ph: 9224 3778 / 9224 3749

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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

**Referral form link** [Silver Chain – Respiratory Care/Referral](#)

**Other information** N/A

**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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## 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** Access to HLP 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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## 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 AHS](#)

**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>

**Other information** N/A

**Cost** Free.

**Location** Armadale Health Service.

**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** [Heart Foundation](#)

**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

[Program Brochure](#)


**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

**Referral method**

**Referral form link**

  
EMHS Aboriginal  
Healthy Lifestyle Proc

**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](mailto:EMHS.HealthyLifeStylePrograms@health.wa.gov.au).  
Ph: 9224 3778 / 9224 3749

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## Arche Health Community Pain Management Service

**Relevant conditions** Chronic pain.

The Community 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.

**Service description** 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 Community 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** [Community 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**

- GP
- Physio.

**Referral method**

Fax completed referral form to 9458 8733

**Referral form link**

[Community Pain Management Service/Referral](#)

**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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## Bladder and Bowel Health Australia

**Relevant conditions** Contenance 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.

**Referral form link** N/A

**Other information** N/A

**Cost** Free.

**Location** Suite 5, The Perron Centre  
61 Kitchener Avenue  
Victoria Park WA 6100

**Contact phone** 1800 330 066

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## East Metropolitan Health Service- Aboriginal Healthy Lifestyle Programs 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

[Program Brochure](#)

**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**

- GP/Health professional
- Self-referral (however requires doctors clearance)

**Referral method**

Please complete and email the form below



**Referral form link**

JLWD & PDC Referral  
Form\_EMHS.pdf

**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

**Contact phone**

Email: [EMHS.HealthyLifeStylePrograms@health.wa.gov.au](mailto:EMHS.HealthyLifeStylePrograms@health.wa.gov.au).  
Ph: 9224 1981

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## 360 Health + Community 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** Fax completed referral form to 9527 1193.  
If patient is self-referring contact 1300 706 922 to speak to the team.

**Referral form link** [DESMOND/Referrals](#)

**Other information** DESMOND workshops are held regularly throughout the year with a review session one month after attendance. Contact 360 for upcoming dates.

**Cost** Free/\$30.

**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 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](#)

**Other information**

If patient also required allied health services from 360 Health + Community, also attached a GPMP/TCA and allied health referral forms:

[360 Health + Community – Allied Health referral](#)

**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

<b>Relevant conditions</b>	At risk patients, type 2 diabetes, cardiovascular disease, chronic renal disease, musculoskeletal conditions and chronic respiratory disease.
<b>Service description</b>	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.
<b>Website</b>	<a href="#">360 Health + Community – HLP</a>
<b>Eligibility criteria</b>	N/A
<b>Who can refer</b>	<ul style="list-style-type: none"><li>• GP referral</li><li>• patients can contact 360 directly if they don't have a GP.</li></ul>
<b>Referral method</b>	Fax completed referral form to: 9527 1193
<b>Referral form link</b>	<a href="#">360 Health + Community – HLP/Referrals</a>
<b>Other information</b>	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.
<b>Cost</b>	Access to HLP 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.
<b>Location</b>	5/51A Church Ave, Armadale 6112 (available at multiple locations across Perth metro area)
<b>Contact phone</b>	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 an endocrinologist, 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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## 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](mailto: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.





## Armadale Health Service Nutrition and Dietetics 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.  
Referrals for outpatient nutrition and dietetic services can be made to the multidisciplinary [Community Rehabilitation](#) service and the [Diabetes Education](#) service.

**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.

**Other information** N/A

**Cost** Free

**Location** Armadale Community Health and Development Centre  
3056 Albany Highway, Armadale

**Contact phone** 9391 2361

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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.



## 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](#)

**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 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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For a comprehensive directory of Dietitians please visit the [National Health Services Directory](#). These services can be accessed through a GP Management Plan.



## 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

**Referral form link** N/A

**Other information** N/A

**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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## East Metropolitan Health Service- Aboriginal Healthy Lifestyle Programs I'm Moordidjabinj (Becoming Strong)

**Relevant conditions** N/A

**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

[Program Brochure](#)

**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

**Referral method**

**Referral form link**

**Other information** The program is a 6 week program

**Cost** Free

**Location** Multiple locations

**Contact phone** Email: [EMHS.HealthyLifeStylePrograms@health.wa.gov.au](mailto:EMHS.HealthyLifeStylePrograms@health.wa.gov.au)  
Ph: 9224 3778 / 9224 3749

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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 – Walking and Cycling](#)

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## Living Longer Living Stronger

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** [Living Longer Living Stronger](#)

**Eligibility criteria** N/A

**Who can refer**

- GP
- allied health

**Referral method** See instructions on website: <http://www.llswa.org.au/referrals/>

**Referral form link** Printable referral form: [Living Longer Living Stronger/Referral](#)

**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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For a comprehensive directory of exercise physiologist please visit the [National Health Services Directory](#). These services can be accessed through a GP Management Plan.



## 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** [360 Health + Community/ Exercise Physiology](#)

**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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For a comprehensive directory of exercise physiologist please visit the [National Health Services Directory](#). These services can be accessed through a GP Management Plan.



## 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

**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** [Home Hospital Post-Acute](#)

**Other information** N/A

**Cost** Free

**Location** Service provided in patients home.

**Contact phone** 1300 466 346

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**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 Enabling Environments Project
- Counselling
- Education Workshops
- Behaviour Management Advisory Service
- Respite Options
- Art Programmes.

**Website** [Alzheimer's Australia](#)

**Eligibility criteria** N/A

**Who can refer** Self-referral

**Referral method** Phone: 9388 2800

**Referral form link** N/A

**Other information** N/A

**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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## Dementia Behaviour Management Advisory Service (DBMAS)

**Relevant conditions** Patients with dementia

**Service description**

The dementia behaviour management advisory service is a national free service funded by the Australia Government and operated and administered by Dementia Support Australia (DSA)

We provide individualised support for the carers of people living with dementia whose behavioural and psychological needs are rapidly changing and impacting on the person's care and quality of life.

The [Severe Behaviour Response Team](#) are a mobile workforce of staff including nurse practitioners, nurses, allied health and specialist staff - available to provide timely expertise and advice to Commonwealth funded approved residential aged care providers requiring assistance with addressing the needs of people with severe and very severe Behavioural and Psychological Symptoms of Dementia (BPSD).

**Website** [DBMAS](#)

**Eligibility criteria** Our clients are people living with dementia, care workers, health professionals and family carers who are supporting a person with dementia and behavioural and psychological changes.

**Who can refer** Self-referral

**Referral method** Call 1800 699 799  
Or alternatively complete the [online referral form](#)

**Referral form link** [Online referral form](#)

**Other information** N/A

**Cost** N/A

**Location** Unit 17A  
151 Herdsman Parade  
Wembley WA 6014

**Contact phone** Phone: 1800 699 799

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## 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](#)

#### 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

### Location

#### 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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## Motor Neurone Disease WA (MNDWA)

**Relevant conditions** Motor Neurone Disease

The Motor Neurone Disease Association of WA (MNDWA) 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 through our [MND Advisory Service](#), connecting those living with MND to the services that they require.

**Service description** MNDWA also provides education and support groups, through our [You, Me and MND Program](#), equipment, [wheelchair accessible transport](#) 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](mailto:admin@mndawa.asn.au)

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## Multiple Sclerosis of WA (MSWA)

**Relevant conditions** All neurological conditions

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.

**Service description**

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.

**Referral form link**

[MSWA online form](#)

**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

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.

**Service description**

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](mailto: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

<b>Relevant conditions</b>	Parkinson's disease
<b>Service description</b>	<p>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.</p> <p>Services offered include;</p> <ul style="list-style-type: none"><li>• Parkinson's nurse specialists</li><li>• Seminars</li><li>• Support groups</li><li>• Support programs (includes Dance for Parkinson's, Park yoga, Parkin Song and Tai Chi)</li></ul>
<b>Website</b>	<a href="#">Parkinson's WA</a>
<b>Eligibility criteria</b>	Clients with Parkinson's Disease, their families or carers
<b>Who can refer</b>	<ul style="list-style-type: none"><li>• Self-referral</li><li>• Any health professional</li></ul>
<b>Referral method</b>	See website for details as to how to contact or alternatively call the number below for assistance
<b>Cost</b>	Membership starts from \$36 per year. For more information regarding membership see <a href="#">Parkinson's WA Membership</a>
<b>Location</b>	<p>Support groups and programs are offered at various locations around the Perth metro area</p> <p>The Parkinson's nurse specialist can visit a patient in their home as required.</p>
<b>Contact phone</b>	Phone: (08) 6457 7373 Email: <a href="mailto:info@parkinsonswa.org.au">info@parkinsonswa.org.au</a>

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## Bethesda Metropolitan Palliative Care Consultancy Service

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:

### Service description

- 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](mailto:MPaCCS@bethesda.org.au)

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## Silver Chain Palliative Care

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.

### Service description

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.

### Referral form link

[Silver Chain – Palliative Care](#)

### Other information

N/A

### Cost

Free of charge or contribution towards the cost.

### Contact phone

General enquires: 9242 0242

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## Community Physiotherapy Service

**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 joint 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](mailto: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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For a comprehensive directory of physiotherapists please visit the [National Health Services Directory](#). These services can be accessed through a GP Management Plan.



## 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](#)

**Eligibility criteria** N/A

**Who can refer** N/A

**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

**Referral form link** [Silver Chain – Physiotherapy/Referral](#)

**Other information** N/A

**Cost** Free of charge or contribution towards the cost.

**Location** N/A

**Contact phone** 9242 0242

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For a comprehensive directory of physiotherapists please visit the [National Health Services Directory](#). These services can be accessed through a GP Management Plan.



## East Metropolitan Health Service- Aboriginal Healthy Lifestyle Programs Moorditj Djena (Strong Feet)

**Relevant disciplines**

- Podiatrist
- Aboriginal Health worker
- Dietitian
- Diabetes Educator

**Relevant conditions**

- Diabetes
- Vascular Disease,
- Neuropathy
- Obesity
- Foot Deformity
- Ulceration
- Chronic foot problems

Podiatrists - Assess your feet (Djena) for problems, check blood flow, sensation and provide required treatment. All aspects of Podiatry are covered including 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.

**Service description**

Aboriginal Health workers – Provide health checks, including blood pressure, blood glucose levels, health education and cultural support.

Dietitian – Talk about healthy eating for chronic diseases, ideas for low cost meals and help with recipes to reduce fat, sugar and salt

Diabetes Educator – Help control blood sugar levels, check medications and assist with insulin management

**Eligibility criteria**

- Aboriginal, Torres Strait Islander or Partner of and aboriginal/TSI person
- ≥18 years old

**Who can refer**

Anyone – walk in service although referrals from GP, Care Coordinators, Nurses etc help with gathering critical health information

**Referral method** Fax/Phone/Walk-in

**Referral form link** N/A

**Cost** Free Service

**Location** Multiple locations. Call for details

**Contact phone** Phone: (08) 9278 9922  
Fax: (08) 9250 1419

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## 360 Health and Community Podiatry

**Relevant conditions** Type 1 and type 2 diabetes

**Service description** 360 offer a comprehensive diabetic foot assessment and screening for newly diagnosed patients and those with ongoing diabetes. Patients will receive education and advice on foot care, footwear and be informed on the status and maintenance of their foot health.

**Website** [360 Health + Community/Podiatry](#)

**Eligibility criteria** N/A

**Who can refer**

- allied health referral
- GP referral
- self-referral

**Referral method** Fax completed referral form to: 9527 1193

**Referral form link** [360 Health + Community/Allied Health Referral](#)

**Other information** Referral not needed. Anyone can access podiatry services.

**Cost** Variable. Medicare Rebate is 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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For a comprehensive directory of podiatrist please visit the [National Health Services Directory](#). These services can be accessed through a GP Management Plan.



## Armada 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

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





## 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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## 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  $\geq 65$  years or  $\geq 50$  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

[ACAT Referral AHS](#)

### Cost

Free.

### Contact phone

1800 200 422

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## Aged Care Guide

<b>Service description</b>	<p>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.</p> <p>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.</p>
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<b>Website</b>	<a href="#">Aged Care Guide</a>
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<b>Eligibility criteria</b>	<p>Individual criteria to accessing services will apply.</p> <p>Visit the website for more information on ACAT and RAS assessments and how to access assistance in the home or residential care.</p>
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<b>Who can refer</b>	N/A
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<b>Referral method</b>	N/A
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<b>Referral form link</b>	N/A
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<b>Cost</b>	Free
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<b>Contact phone</b>	N/A
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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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## 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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## Connect Groups

**Relevant conditions** N/A

**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](#)

**Eligibility criteria** N/A

**Who can refer** N/A

**Referral method** N/A

**Referral form link** N/A

**Cost** N/A

**Location** N/A

**Contact phone** Phone: 9364 6909

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## 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.

**Referral form link** [Community rehabilitation referral](#)



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

**Other information**

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

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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.





**Relevant conditions** Sub-acute rehabilitation

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.

**Service description**

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.

### Website

N/A

### 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 and require maintenance therapy

### Who can refer

Hospital allied health staff.



## Referral Process

To refer the patient, the referrer must:

1. Contact the relevant RITH site's Intake Therapist / Coordinator to discuss the referral BEFORE the patient is discharged from the hospital. See contact details.
2. Complete the RITH referral form ensuring all information is clear, concise and legible.
3. Ensure RITH consent section is signed by the patient, including the separate RITH Contract when indicated.
4. Ensure the Risk Identification section is completed.
5. Send the completed forms and all other relevant handover information to RITH via fax / email. Refer to contact details.

## Referral method

### 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, the referrer must:

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 the RITH referral and all other relevant forms / handover indicated (as per above process).
4. Send the completed documentation to the relevant RITH sites via fax / email. Refer to contact details.

Referral form link	<a href="#">Rehabilitation in the Home/Referral Form</a> (only accessible to hospital staff)
Other information	N/A
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 Home Independence Program (HIP)

**Relevant conditions** N/A

**Service description** The Home Independence Program is a short term program designed to help improve your function and confidence to undertake daily tasks, especially after a fall. The team consists of:

- HIP coordinators
- Physiotherapist
- Occupational Therapist
- Care Aides

**Website** [Silver Chain – HIP](#)

**Eligibility criteria** Requires a referral from the Regional Assessment Service to access service: 1300 785 415

**Who can refer**

- GP
- allied health

**Referral method** Requires a referral from the Regional Assessment Service to access service. Call 1300 785 415 and request Silver Chain HIP service.

**Referral form link** N/A

**Other information** N/A

**Cost** It may be free of charge or you may need to contribute to the cost.

**Location** Services are provided in the home.

**Contact phone** Metro callers: 9242 0242  
Country callers: 1300 650 803

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## Silver Chain Personal Enablement Program (PEP)

**Relevant conditions** N/A

**Service description** Short term services to assist safe discharge home. Team of occupational therapists, physiotherapists, therapy assistants and care aids work with patient to regain confidence and strength, so they can remain living at home safely and effectively.

**Website** [Silver Chain – PEP](#)

**Eligibility criteria**

Patient must be:

- a current inpatient when referred to PEP
- HACC eligible (ongoing functional disability)
- Not receiving Community Aged Care Package (CACP) or on waitlist
- Have potential to improve function independence

**Who can refer** Allied health staff (hospital)

**Referral method** Hospital referrals can be made during business hours Monday - Friday by calling the Silver Chain Contact Centre on 9242 0347. PEP referrals will be screened by the Allied Health Liaison, who will discuss with the referrer the individual needs of the client.

**Referral form link** [PEP Referral form](#)

**Other information** N/A

**Cost** Contribution towards the cost.

**Location** Service provided in patients home.

**Contact phone** 9242 0347

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## VisAbility (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** [www.visability.com.au](http://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](mailto:info@visability.com.au)

**Referral form link** [Visibility Referral form](#)

**Other information** N/A

**Cost** Free

**Location** The Perron Centre, 61 Kitchener Avenue, Victoria Park 6979

**Contact phone** 1800 847 466 or 9311 8202

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## Arche Health Active Measures

<b>Service description</b>	<p>Active Measures is a weight management program operating at our Bentley office to service the ongoing chronic disease needs of the community:</p> <ul style="list-style-type: none"><li>• one-on-one sessions with an Accredited Exercise Physiologist</li><li>• one-on-one appointments with an Accredited Practising Dietitian</li><li>• group education sessions run by an Accredited Practising Dietitian.</li></ul>
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<b>Website</b>	<a href="#">Arche Health – Active Measures</a>
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<b>Eligibility criteria</b>	Over 18 years old
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<b>Who can refer</b>	<ul style="list-style-type: none"><li>• allied health</li><li>• GP</li><li>• hospital</li><li>• self-referral</li></ul>
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<b>Referral method</b>	<p>Fax completed referral form to: 9458 0555 Email: <a href="mailto:activemeasures@archehealth.com.au">activemeasures@archehealth.com.au</a></p>
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Please refer to the website for additional requirements for those Medicare – eligible patients with a GPMP

<b>Referral form link</b>	<a href="#">Arche Health – Active Measures</a>
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<b>Other information</b>	<p>Group nutrition education sessions are run for all members of the community and a referral is not required. Please refer to website for details.</p>
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<b>Cost</b>	<a href="#">Active Measures/Fee Schedule</a>
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<b>Location</b>	Unit 4/1140 Albany Highway, Bentley 6102
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<b>Contact phone</b>	9458 0596
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## Diabetes WA SHED- IT

<b>Service description</b>	<p>A low cost weight loss program designed by men, for men. The program will teach you all about the science of long-term, sustainable weight management. During the program you can expect to:</p> <ul style="list-style-type: none"><li>• Improve your fitness level and eating habits</li><li>• Improve your heart health and wellbeing</li><li>• Lose weight and keep it off</li></ul> <p>You will receive a logbook, online food diary, pedometer and tape measure and weekly emails.</p>
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**Website** [Diabetes WA- SHED-IT](#)

**Eligibility criteria** N/A

**Who can refer**

- Self-referral

**Referral method** N/A

**Referral form link** N/A

**Other information** Visit the website to purchase the program through the Diabetes WA Online shop

**Cost** \$75

**Location** N/A

**Contact phone** Phone: 1300 001 880

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

### WAPHA Disclaimer

While the Australian Government Department of Health, via WAPHA, has contributed funding to Armadale Health service, the information contained in this report does not necessarily reflect the views of the Australian Government and/or WAPHA and is not advice that it is provided, or information that is endorsed, by the Australian Government and/or WAPHA. The Australian Government and/or WAPHA is not responsible in negligence or otherwise for any injury, loss or damage however arising from the use of or reliance on the information provided herein.

