

Mental Health Stepped Care Referral Form

Date: _____

<p>Eligibility Criteria (Must be completed)</p> <p><input type="checkbox"/> Low Income (e.g. Health Care Card/ Disability Support Pension or no source of income) Card No _____ OR</p> <p><input type="checkbox"/> Low to moderate suicide risk Please complete risk assessment (Low income criteria is not applicable)</p> <p><input type="checkbox"/> Medicare Card Holder OR</p> <p><input type="checkbox"/> Asylum Seeker</p> <p><input type="checkbox"/> Resides or works/studies within EMPHN catchment</p>	<p>Consumer prefers to be seen at:</p> <table border="1" style="width: 100%;"> <thead> <tr> <th style="width: 33%;">North East</th> <th style="width: 33%;">Inner East</th> <th style="width: 33%;">Outer East</th> </tr> </thead> <tbody> <tr> <td> <input type="checkbox"/> Eltham (Health Ability) <input type="checkbox"/> Epping (Banyule CHS Whittlesea) <input type="checkbox"/> Greensborough (Banyule CHS) <input type="checkbox"/> Heidelberg West (Banyule CHS) <input type="checkbox"/> Kinglake (Nexus Primary Health) <input type="checkbox"/> Mill Park (Banyule CHS Whittlesea) <input type="checkbox"/> Wallan (Nexus Primary Health) <input type="checkbox"/> Whittlesea (Banyule CHS Whittlesea) </td> <td> <input type="checkbox"/> Box Hill (Carrington Health) <input type="checkbox"/> Doncaster East (Access Health and Community) <input type="checkbox"/> Glen Waverley (Link Health and Community) <input type="checkbox"/> Hawthorn (Access Health and Community) </td> <td> <input type="checkbox"/> Belgrave (Mentis Assist) <input type="checkbox"/> Boronia (Mentis Assist) <input type="checkbox"/> Healesville (Mentis Assist) <input type="checkbox"/> Ringwood (Mentis Assist) <input type="checkbox"/> Yarra Glen (Mentis Assist) </td> </tr> </tbody> </table> <p><input type="checkbox"/> Prefers phone / video / web-based support</p>	North East	Inner East	Outer East	<input type="checkbox"/> Eltham (Health Ability) <input type="checkbox"/> Epping (Banyule CHS Whittlesea) <input type="checkbox"/> Greensborough (Banyule CHS) <input type="checkbox"/> Heidelberg West (Banyule CHS) <input type="checkbox"/> Kinglake (Nexus Primary Health) <input type="checkbox"/> Mill Park (Banyule CHS Whittlesea) <input type="checkbox"/> Wallan (Nexus Primary Health) <input type="checkbox"/> Whittlesea (Banyule CHS Whittlesea)	<input type="checkbox"/> Box Hill (Carrington Health) <input type="checkbox"/> Doncaster East (Access Health and Community) <input type="checkbox"/> Glen Waverley (Link Health and Community) <input type="checkbox"/> Hawthorn (Access Health and Community)	<input type="checkbox"/> Belgrave (Mentis Assist) <input type="checkbox"/> Boronia (Mentis Assist) <input type="checkbox"/> Healesville (Mentis Assist) <input type="checkbox"/> Ringwood (Mentis Assist) <input type="checkbox"/> Yarra Glen (Mentis Assist)
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1. REFERRER DETAILS

Referrer name: _____ Relationship to Consumer: _____
 Organisation: _____
 Address: _____
 Suburb: _____ Postcode: _____
 Phone: _____ Fax: _____

2. CONSUMER DETAILS

First Name: _____ Surname: _____
 DOB: _____ Gender: _____ Phone: _____
 Email: _____
 Address: _____
 Suburb: _____ Postcode: _____
 Aboriginal Torres Strait Islander background Culturally and Linguistically Diverse Background
 Country of Birth: _____ Interpreter Required (Language/Auslan): _____
 Income Source: _____ Mobility/Disability Needs: _____
 Homelessness: Yes No Comments (including at risk): _____
 NDIS package approved: Yes No Comments: _____

3. EMERGENCY CONTACT

If the consumer is a child, please write details of the parent or guardian who is responsible for decisions about treatment.

First Name: _____ Surname: _____
 Gender: _____ Relationship to Consumer: _____
 Phone: _____ Email: _____

Fax this completed form to 8677 9510. For any queries, please call 9800 1071.

4. CLINICAL INFORMATION

Note: Only complete this section if this information has not been provided in a Treatment Plan

Presenting Issues:
Reason for Referral to Stepped Care:
Mental Health Diagnosis (if known):
Medication (if known):
Relevant Medical History:
Substance Use:
Other Impacting factors (including risk factors):

Please attach any relevant/supporting documentation: Mental Health Care Plan, Assessment notes/Outcome measure/Discharge summary

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RISK ASSESSMENT (MUST BE COMPLETED)

If your consumer is presenting in an acute psychiatric crisis or risk is high, please call your local area mental health service

Current Suicidal Thoughts:	<input type="checkbox"/> No	<input type="checkbox"/> Yes : _____		
Current Suicidal Plan:	<input type="checkbox"/> No	<input type="checkbox"/> Yes : _____		
Current Suicidal Intent:	<input type="checkbox"/> No	<input type="checkbox"/> Yes : _____		
Recent Suicide attempt in the last three months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Relevant History:	_____			
Suicide Risk Level:	<input type="checkbox"/> Not Apparent	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High

Current Self Harm Thoughts:	<input type="checkbox"/> No	<input type="checkbox"/> Yes : _____		
Current Self Harm Plan:	<input type="checkbox"/> No	<input type="checkbox"/> Yes : _____		
Current Self Harm Intent:	<input type="checkbox"/> No	<input type="checkbox"/> Yes : _____		
Current behaviours:	_____			
Relevant History:	_____			
Self-Harm Risk Level:	<input type="checkbox"/> Not Apparent	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High

Current Harm to Others Thoughts:	<input type="checkbox"/> No	<input type="checkbox"/> Yes : _____		
Current Harm to Others Plan:	<input type="checkbox"/> No	<input type="checkbox"/> Yes : _____		
Current Harm to Others Intent:	<input type="checkbox"/> No	<input type="checkbox"/> Yes : _____		
Relevant History:	_____			
Risk to others:	<input type="checkbox"/> Not Apparent	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High

Risk of harm from others: <input type="checkbox"/> Yes <input type="checkbox"/> No
Comments: _____

CURRENT RISK MANAGEMENT PLAN
<input type="checkbox"/> Yes , date of plan: _____
<input type="checkbox"/> No , preparation of plan will be completed on _____ By: _____
<input type="checkbox"/> N/A Please comment: _____

Comments: _____

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CONSENT

Consent to participate:

Eastern Melbourne PHN (EMPHN) and providers who run services that EMPHN funds are required to collect and use information about you. This includes personal information, and information about the services you are receiving. This information is used by staff members involved in delivering services to you, and by staff at EMPHN. This information is used and shared to ensure you get the right service for your needs, to monitor service delivery and performance, and evaluate and make improvements to services. This consent condition is mandatory – to receive services, you must agree.

I/ parent/guardian consents to receive services and for the collection and use of information about me and the services I receive, as outlined above. Yes No

EMPHN funded services are evaluated to ensure they are meeting the needs of consumers and our community. You may be contacted to participate in additional evaluation activities associated with your care. If contacted, you can choose whether you wish to take part or not.

Consent to collect and share information with other services:

I/ parent/guardian consents to the collection and sharing of all relevant information with other service providers relevant to assist my/my child’s overall care. I understand that my information will not be shared if I do not consent. Yes No

If YES, please list all service providers you consent to being contacted by EMPHN or EMPHN’s funded service provider and discussing your/your child’s care (e.g. GP, Psychiatrist, CAT team, allied health professionals etc.).

	Name	Organisation	Contact details
Please select			Phone: Fax:
Please select			Phone: Fax:
Please select			Phone: Fax:
Please select			Phone: Fax:

Consent to share anonymised data with the Department of Health:

As the overall funder, the Department of Health is interested in anonymised data which will be used for evaluation purposes to improve mental health services in Australia. This anonymised data includes information about you, such as your gender, date of birth and types of services received, but **does not** include any information that could identify you (e.g. your name, address or Medicare number).

I / parent/guardian consents to EMPHN providing anonymised data about me and the services I receive to the Department of Health. I understand that my information will not be shared if I do not consent. Yes No

Consumer Signature: **Date:**/...../.....

Verbal Consent Provided by consumer **Referrer Signature:** **Date:**/...../.....

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