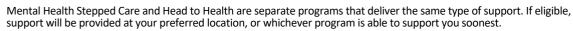
Mental Health Stepped Care & Head to Health Referral Form





Date:	Consumer prefers to be seen at:					
	North East	Inner East	Outer East			
Please indicate if consumer presents with moderate risk of suicide Eligibility Criteria (Must be completed) Unable to afford or access a similar service (e.g. due to low income, lack of service availability Resides or works/studies within the EMPHN catchment	Eltham (Health Ability) Epping (Banyule CHS) Greensborough (Banyule CHS) Heidelberg West (Banyule CHS) Kinglake (Nexus Primary Health) Wallan (Nexus Primary Health)	Box Hill (HealthAbility) Doncaster East (Access Health & Community) Hawthorn (Access Health and Community)	Belgrave (Inspiro) Boronia (HealthAbility) Healesville (Oonah Belonging Place) Lilydale (Inspiro) Ringwood (Access Health & Community) Yarra Junction (Inspiro)			
1. REFERRER DETAILS	☐ Prefers phone / video	/ web-based support				
Referrer name:	Polationsh	ain to consumer:				
		•				
Organisation:Address:						
Phone:						
2. CONSUMER DETAILS	Surnama					
First Name: Gender:						
Address:Gender						
Suburb:		łe:				
Email:		<u> </u>				
I do NOT consent for sending mail to abo		e messages on phone	receiving SMS			
Currently homeless: Yes No Comm	nents if at risk of homelessnes	SS:				
Aboriginal Torres Strait Islando	er background Cultura	lly and Linguistically Dive	erse Background			
Country of Birth: I	nterpreter Required (Languag	ge/Auslan):				
Mobility/Disability Needs:						
Income Source:						
NDIS: Has NDIS funding in place Comments:	☐ Does not have NI	DIS funding in place				
3. EMERGENCY CONTACT If the consumer is a child, please write detail.	s of the narent or avardian w	ha is responsible for doc	isions about treatment			
First Name:						
	tionship to Consumer					

4. CLINICAL INFORMATION

Note: Only complete this section if this information has not been provided in attached documentation

Presenting issues:
Reason for referral:
Mental health diagnosis (if known):
Medication (if known):
Relevant medical history:
Substance use/Addictive behaviours:
Other impacting factors (including risk factors):

<u>Please attach any relevant/supporting documentation such as: Mental Health Treatment</u> <u>Plan/NDIS plan/Assessment notes/Outcome measures/Discharge summary</u>

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:		No		Ye	s :		
Current Suicidal Plan:		No		Ye	s :		_
Current Suicidal Intent:		No					
Recent Suicide attempt in the I	ast t	hree	months?		Yes	☐ No	
Relevant History:							
Suicide Risk	Lev	el:	☐ Not	Appa	arent	Low	☐ High
Current Self Harm Thoughts:		No		Yes	:		
Current Self Harm Plan:		No		Yes	:		
Current Self Harm Intent:		No		Yes	:		
Current behaviours:							
Relevant History:							
Self-Harm Risk Level: Not Apparent Low Medium High							
Current Harm to Others Thoug	hts:		No		Yes :		
Current Harm to Others Plan:			No				
Current Harm to Others Intent	::		No				
Relevant History:							
Risk to others: Not Apparent Low Medium High							
Risk of harm from others:							
Comments:							

Additional Comments:

Name: D.O.B								
1. Consent to receive service and for sharing of service delivery information: EMPHN and EMPHN funded providers 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 only by EMPHN and EMPHN funded providers involved in delivering services to you. This information is used and shared to ensure you get the right service for your needs, to monitor service delivery, performance, evaluate and make improvements to services. This consent condition is mandatory to receive services.								
As the funder, the to improve improve includes information	deidentified data with Department DoH is interested in deidenter mental health and alcohol a about you, such as your generated any information that could	tified data which is used and other drug services der, date of birth and ty	in Australia. This data pes of services received,					
3. Consent to collection and sharing of information with other services:								
Please list all service providers, carers and supports you consent to being contacted by EMPHN or EMPHN's funded service providers to discuss you/your dependent's provision of care and planning (e.g. GP, Psychiatrist, CAT team, allied health professionals etc.).								
Profession	Name	Organisation	Contact details					
			Phone: Fax:					
			Phone: Fax:					
			Phone: Fax:					
needs of consumers a research activities associated as a second of the s	tes are at times involved in evaluand our community. You may be ciated with your care. If contacted, consent to receive service and for the indition is mandatory to receive service.	e contacted to participate you can choose whether you e sharing of service delivery	in additional evaluation or use wish to take part or not.					
		☐ Yes ☐ No						
2. I / parent/guardian consent to share deidentified data with DoH. I understand that my information will not be shared if I do not consent. Yes No								
services, carers and sup	onsent to the collection and sharin pports relevant to assist my/dependershared if I do not consent.							
mormation will not be	silarea il ruo not consent.	☐ Yes ☐ No						
Consumer Signature:			Date: / /					
<u>or</u>								
Referrer Signature (Ve	rbal consent provided by consume	er):	Date: / /					

CONSENT - Must be completed and signed (including consent tick boxes)