

# Mental Health Stepped Care & Head to Health Referral Form

Mental Health Stepped Care and Head to Health are separate programs that deliver the same type of support. If eligible, support will be provided at your preferred location, or whichever program is able to support you soonest.

Date: \_\_\_\_\_

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

Consumer prefers to be seen at:		
North East	Inner East	Outer East
<input type="checkbox"/> <b>Eltham</b> (Health Ability) <input type="checkbox"/> <b>Epping</b> (Banyule CHS) <input type="checkbox"/> <b>Greensborough</b> (Banyule CHS) <input type="checkbox"/> <b>Heidelberg West</b> (Banyule CHS) <input type="checkbox"/> <b>Kinglake</b> (Nexus Primary Health) <input type="checkbox"/> <b>Wallan</b> (Nexus Primary Health)	<input type="checkbox"/> <b>Box Hill</b> (HealthAbility) <input type="checkbox"/> <b>Doncaster East</b> (Access Health & Community) <input type="checkbox"/> <b>Hawthorn</b> (Access Health and Community)	<input type="checkbox"/> <b>Belgrave</b> (Inspiro) <input type="checkbox"/> <b>Boronia</b> (HealthAbility) <input type="checkbox"/> <b>Healesville</b> (Oonah Belonging Place) <input type="checkbox"/> <b>Lilydale</b> (Inspiro) <input type="checkbox"/> <b>Ringwood</b> (Access Health & Community) <input type="checkbox"/> <b>Yarra Junction</b> (Inspiro)
<input type="checkbox"/> Prefers phone / video / web-based support		

### 1. REFERRER DETAILS

Referrer name: \_\_\_\_\_ Relationship to consumer: \_\_\_\_\_

Organisation: \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### 2. CONSUMER DETAILS

First Name: \_\_\_\_\_ Surname: \_\_\_\_\_

DOB: \_\_\_\_\_ Gender: \_\_\_\_\_ Pronouns: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ Postcode: \_\_\_\_\_

Email: \_\_\_\_\_

I do **NOT** consent for  sending mail to above address  leaving voice messages on phone  receiving SMS

Currently homeless: Yes  No  Comments if at risk of homelessness: \_\_\_\_\_

Aboriginal  Torres Strait Islander background  Culturally and Linguistically Diverse Background

Country of Birth: \_\_\_\_\_ Interpreter Required (Language/Auslan): \_\_\_\_\_

Mobility/Disability Needs: \_\_\_\_\_

Income Source: \_\_\_\_\_

**NDIS:**  Has NDIS funding in place  Does not have NDIS funding in place

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: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship to Consumer: \_\_\_\_\_

#### 4. CLINICAL INFORMATION

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

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

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

## 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.**

<p>Current Suicidal Thoughts:    <input type="checkbox"/> <b>No</b>            <input type="checkbox"/> <b>Yes</b> : _____</p> <p>Current Suicidal Plan:        <input type="checkbox"/> <b>No</b>            <input type="checkbox"/> <b>Yes</b> : _____</p> <p>Current Suicidal Intent:      <input type="checkbox"/> <b>No</b>            <input type="checkbox"/> <b>Yes</b> : _____</p> <p>Recent Suicide attempt in the last three months?    <input type="checkbox"/> <b>Yes</b>    <input type="checkbox"/> <b>No</b></p> <p>Relevant History: _____</p> <p style="text-align: center;"><b>Suicide Risk Level:</b>    <input type="checkbox"/> <b>Not Apparent</b>        <input type="checkbox"/> <b>Low</b>        <input type="checkbox"/> <b>Medium</b>        <input type="checkbox"/> <b>High</b></p>
<p>Current Self Harm Thoughts:        <b>No</b>            <input type="checkbox"/> <b>Yes</b> : _____</p> <p>Current Self Harm Plan:            <b>No</b>            <input type="checkbox"/> <b>Yes</b> : _____</p> <p>Current Self Harm Intent:            <b>No</b>            <input type="checkbox"/> <b>Yes</b> : _____</p> <p>Current behaviours: _____</p> <p>Relevant History: _____</p> <p style="text-align: center;"><b>Self-Harm Risk Level:</b>    <input type="checkbox"/> <b>Not Apparent</b>        <input type="checkbox"/> <b>Low</b>        <input type="checkbox"/> <b>Medium</b>        <input type="checkbox"/> <b>High</b></p>
<p>Current Harm to Others Thoughts:    <input type="checkbox"/> <b>No</b>            <input type="checkbox"/> <b>Yes</b> : _____</p> <p>Current Harm to Others Plan:        <input type="checkbox"/> <b>No</b>            <input type="checkbox"/> <b>Yes</b> : _____</p> <p>Current Harm to Others Intent:      <input type="checkbox"/> <b>No</b>            <input type="checkbox"/> <b>Yes</b> : _____</p> <p>Relevant History: _____</p> <p style="text-align: center;"><b>Risk to others:</b>    <input type="checkbox"/> <b>Not Apparent</b>        <input type="checkbox"/> <b>Low</b>        <input type="checkbox"/> <b>Medium</b>        <input type="checkbox"/> <b>High</b></p>
<p><b>Risk of harm from others:</b>    <input type="checkbox"/> <b>Yes</b>    <input type="checkbox"/> <b>No</b></p> <p>Comments: _____</p>

Additional Comments:

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

**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.**

**2. Consent to share deidentified data with Department of Health (DoH):**

As the funder, the DoH is interested in deidentified data which is used for evaluation purposes to improve improve mental health and alcohol and other drug services in Australia. This 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).

**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:

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

1. I/ parent/guardian consent to receive service and for the sharing of service delivery information, as outlined above. **This consent condition is mandatory to receive services.**

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

3. I/ parent/guardian consent to the collection and sharing of all relevant information with other services, carers and supports relevant to assist my/dependent's overall provision of care. I understand that my information will not be shared if I do not consent.

Yes       No

Consumer Signature: .....

Date: / /

or

Referrer Signature (Verbal consent provided by consumer): .....

Date: / /