Mental Health Stepped Care Referral Form

Date: _____

Eligibility Criteria (Must be completed)
☐ **Low Income** *(e.g. Health Care Card/ Disability Support Pension or no source of income)* *OR* ☐ **Low to moderate suicide risk** ***Please complete risk assessment*** *(Low income criteria is not applicable)*
◯ **Resides or works/studies within EMPHN catchment**

Consumer prefers to be seen at:		
North East	**Inner East**	**Outer East**
☐ **Eltham** (Health Ability) ☐ **Epping** (Banyule CHS Whittlesea) ☐ **Greensborough** (Banyule CHS) ☐ **Heidelberg West** (Banyule CHS) ☐ **Kinglake** (Nexus Primary Health) ☐ **Mill Park** (Banyule CHS Whittlesea) ☐ **Wallan** (Nexus Primary Health) ☐ **Whittlesea** (Banyule CHS Whittlesea)	☐ **Box Hill** (Carrington Health) ☐ **Doncaster East** (Access Health and Community) ☐ **Glen Waverley** (Link Health and Community) ☐ **Hawthorn** (Access Health and Community)	☐ **Belgrave** (Mentis Assist) ☐ **Boronia** (Mentis Assist) ☐ **Healesville** (Mentis Assist) ☐ **Ringwood** (Mentis Assist) ☐ **Yarra Glen** (Mentis Assist)
☐ **Prefers phone / video / web-based support**		

1. REFERRER DETAILS

Referrer name: _____ Relationship to Consumer: _____

Organisation: _____

Address: _____

Phone: _____ Fax: _____

2. CONSUMER DETAILS

First Name: _____ Surname: _____

DOB: _____ Gender: _____ Phone: _____

Address: _____

Suburb: _____ Postcode: _____

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

Homelessness: ◯ Yes ◯ No Comments (including at risk): _____

☐ Aboriginal ☐ Torres Strait Islander background ☐ Culturally and Linguistically Diverse Background

Country of Birth: _____ Interpreter Required (Language/Auslan): _____

Mobility/Disability Needs: _____

Income source: _____

NDIS: ☐ **Have not applied and needs support** ☐ **Applied and waiting access decision (Please provide documentation)**
☐ **Do not intend to apply** ☐ **Applied and Declined (Please provide reason and documentation)**

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 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

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** ◯ **Yes** : _____

Current Suicidal Plan: ◯ **No** ◯ **Yes** : _____

Current Suicidal Intent: ◯ **No** ◯ **Yes** : _____

Recent Suicide attempt in the last three months? ◯ **Yes** ◯ **No**

Relevant History: _____

Suicide Risk Level: ◯ **Not Apparent** ◯ **Low** ◯ **Medium** ◯ **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 Thoughts: ◯ **No** ◯ **Yes** : _____

Current Harm to Others Plan: ◯ **No** ◯ **Yes** : _____

Current Harm to Others Intent: ◯ **No** ◯ **Yes** : _____

Relevant History: _____

Risk to others: ◯ **Not Apparent** ◯ **Low** ◯ **Medium** ◯ **High**

Risk of harm from others: ◯ **Yes** ◯ **No**

Comments: _____

CURRENT RISK MANAGEMENT PLAN

◯ **Yes,** date of plan: _____

◯ **No,** preparation of plan will be completed on _____ By: _____

◯ **N/A** Please comment: _____

Comments: _____

_____

CONSENT - Must be completed and signed

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) and Department of Health and Human Services (DHHS):

As the funder/s, the DoH and/or DHHS is interested in deidentified data which is used for evaluation purposes to improve mental health 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 and DHHS.** 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: / /