Mental Health Services Referral Form

PHN EASTERN MELBOURNE
An Australian Government Initiative

Date: ____________________

1. REFERRER DETAILS

Name: ____

GP /Psychiatrist Provider Number (where appropriate): _____________________________________

Position and organisation: ____

Phone: _______________________________________ Fax: ____

Address: ____

____ Postcode: ____________

2. CLIENT DETAILS

Name: ____

D.O.B: _____________________________________ Gender: ____________________________________

Aboriginal and/or Torres Strait Islander background: ☐ Yes ☐ No

CALD status: ☐ Yes ☐ No country of birth: ____

Interpreter required (language): ____

Phone: ____

Address: ____

Next of kin: ____ Phone: __________________________________

Mental health and support needs: ____

____

____

Mental health diagnosis (where appropriate):____

Current medication (where appropriate): ____

Current presenting risk:

Risk to self (please tick one): ☐ not apparent ☐ low ☐ med ☐ high comment: ____________________

____

Risk to others (please tick one): ☐ not apparent ☐ low ☐ med ☐ high comment: ____________________

____

Current risk management plan: ____

____

IF YOUR CLIENT IS PRESENTING IN AN ACUTE PSYCHIATRIC CRISIS OR IF RISK IS HIGH, PLEASE CALL YOUR LOCAL AREA MENTAL HEALTH SERVICE

Client's support goals: ____

____

Treatment plan goals: ____

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

3. CONSENT

☐ Client/parent/guardian consent to referral and for transfer of referral documentation to appropriate service provider.

Your client consents to their/ their child's de-identified information being used by EMPHN for evaluation and reporting purposes to the Department of Health. They understand this data, which does not include their name, address or Medicare number, but will include information such as date of birth, gender and types of services they use, will be used for the purposes of improving health services in Australia. Your client understands that their/ their child's information will not be provided to the Department of Health if they indicate they do not consent.

4. PREFERRED PROGRAM (All criteria must be met for program eligibility)

Select below OR ☐ EMPHN to select (go to section 5)

☐ **Psychological Strategies (formerly known as ATAPS)**

Eligibility criteria:

☐ Has a mental health treatment plan ☐ Low income ☐ Low to moderate risk

☐ Diagnosed mental health condition (or at risk of developing a mental health condition for children and Aboriginal and/or Torres Strait Islander people)

Has the client used Medicare Better Access this calendar year? ☐ Yes ☐ No

If yes, number of sessions: ____

Preferred provider/organisation: ____ or EMPHN to select ☐

Suicide Prevention Service

Eligibility criteria:

Low to moderate risk of suicide and/or self-harm

Not suitable for, or currently receiving tertiary services

Patient is provided with Suicide Support Line information sheet for after-hours support

Referral after 3pm (Mon - Thur), or Fri and weekend/public holidays - GP must call 1800 859 585 to book a call back from Suicide Support Line.

Preferred provider/ organisation: ____ or EMPHN to select

☐ **Mental Health Nurse**

Eligibility criteria:

☐ Has a mental health treatment plan

☐ Diagnosed mental health condition

☐ Requires medium to long term care

☐ Functional impairment

☐ At risk of hospitalisation

☐ Not linked with a tertiary service

Preferred provider/organisation: ____ or EMPHN to select ☐

☐ **Support Coordination**

Eligibility criteria:

☐ Appears to have severe and persistent mental health issues ☐ Needs support from multiple services

Preferred provider/organisation: ____ or EMPHN to select ☐

5. Only complete if you would like EMPHN to select a service (tick all that apply)

- ☐ Would benefit from short term psychological intervention
- ☐ Low income
- ☐ Is low to moderate risk
- ☐ Diagnosed mental health condition
- ☐ At risk of developing a mental health condition
- ☐ Would benefit from psycho-social support
- ☐ Has a chronic and complex mental health presentation
- ☐ Receiving support through tertiary services
- ☐ At risk of hospitalisation
- ☐ Significant impairment on functioning due to mental health condition
- ☐ Has a current Mental Health Treatment Plan
- ☐ Has complex needs and would benefit from longer term care coordination support
- ☐ Has a severe and persistent mental health condition
- ☐ Requires support from multiple services
- ☐ Having suicidal/self-harm ideation or self-harming
- ☐ Had recent suicide attempt
- ☐ Has current suicide plan
- ☐ Has current suicidal intent
- ☐ Requires a tertiary service

Additional information (e.g. past treatments, other agencies involved): ____

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