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)* ***Card No***_____ *OR* ☐ **Low to moderate suicide risk** ***Please complete risk assessment*** *(Low income criteria is not applicable)*
◯ **Medicare Card Holder** **OR** ◯ **Asylum Seeker**
◯ **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) ☐ **South Morang** (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: _____

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: ◯ **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: _____

_____

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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
other			Phone: Fax:
other			Phone: Fax:
other			Phone: Fax:
other			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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