Psychosocial Support Service Referral Form

phn EASTERN MELBOURNE
An Australian Government Initiative

Date: ______________________

Eligibility Criteria (Must be completed)

- ☐ Severe episodic mental illness with associated impact on psychosocial functioning
- ☐ Would benefit from time limited psychosocial support
- ☐ Does not have an active NDIS plan
- ☐ Not currently supported or eligible for Early Intervention Psychosocial Support Response (Local Hospital Network funded Psychosocial support service)
- ☐ Lives or works within EMPHN catchment

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: ______________________ Health Care Card: Yes ☐ No ☐

NDIS:

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

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. CONSUMER INFORMATION

Note: Please attach any relevant documentation - Discharge summaries, MHTP, NDIS supportive documentation

Mental health diagnosis (if known), presenting mental health need(s) & medications:
Current physical health need(s):
Addictive Behaviours:
Provide relevant information about the impact of mental health on functioning and outline practical supports needed:
Managing Daily Activities and Responsibilities (e.g. self care, cooking, parenting):
Social skills, friendships and family relationships:
Education/ Employment:
Physical wellbeing:
Life skills (e.g. self confidence, resilience):
List Current and Previous Services (e.g Psychologist or GP) and informal support (family, friend, carer):

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 - 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):

As the funder, the DoH 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 partake.

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: ___/___/___

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