

Psychosocial Support Service Referral Form

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:
<i>Provide relevant information about the impact of mental health on functioning and outline practical supports needed:</i>
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: _____

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 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 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: / /