Mental Health Services Referral Form

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: _____

_____

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

Please inform your patient that their/their child's **de-identified** data may be used for evaluation purposes.

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

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

☐ **Short term focused psychological strategies**

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 ATAPS 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 ATAPS Suicide Support Line.

Preferred provider/ organisation: _____ or ☐ EMPHN to select

☐ **Mental Health Nurse**

Eligibility criteria:

☐ Has a mental health treatment plan ☐ Functional impairment

☐ Diagnosed mental health condition ☐ At risk of hospitalisation

☐ Requires medium to long term care ☐ 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 ☐

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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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