

Psychosocial Support Service Referral Form

Date: _____

Psychosocial Support Services are delivered in the EMPHN catchment by two providers, Neami National and Wellways in partnership with Carrington Health.

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 receiving clinical case management from an area mental health service.
- Lives or works within EMPHN catchment

1. REFERRER DETAILS

Referrer name: _____ Relationship to Consumer: _____
Organisation: _____
Address: _____
Phone: _____ Email: _____ Fax: _____

2. CONSUMER DETAILS

First Name: _____ Surname: _____
DOB: _____ Gender: _____ Pronoun/s: _____ Phone: _____
Address: _____
Suburb: _____ Postcode: _____

I do **NOT** consent for sending mail to above address leaving voice messages on phone receiving SMS

Currently homeless, or at risk? Yes No Identifies as LGBTQIA+: Yes No unknown/ prefer not to say

Aboriginal Torres Strait Islander background Culturally and Linguistically Diverse Background

Country of Birth: _____ Interpreter Required (Language/Auslan): _____

Income source: _____ Health Care Card: Yes No

NDIS:

Have not applied and needs support

Applied and waiting access decision. Date of application: _____

Applied and found to be ineligible (Please provide reason and documentation)

Do not intend to apply

Does not meet eligibility criteria (due to age, residency etc)

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 diagnosis/ presenting physical health need/s: Mobility/Disability Needs: |
| Addictive Behaviours: |
| Complete below sections in context of: Impact of mental health on functioning and capacity building goals |
| 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 Services (e.g Psychologist or GP) and informal support (family, friend, carer) as per above areas: |

RISK ASSESSMENT (MUST BE COMPLETED)

If presenting with an acute psychiatric crisis or risk is high, please call your psychiatric triage 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: _____
Forensic History: Yes No Details: _____
Risk to others: Not Apparent Low Medium High

Risk of harm from others: Yes No
Details: _____

CURRENT RISK MANAGEMENT PLAN

Yes, date of plan: _____

No, preparation of plan will be completed on _____ By: _____

N/A Please comment: _____

If eligible for PSS, please identify preferred gender of worker (although not able to be guaranteed)

Male Female No preference

Any additional information that may support engagement:

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.

Please clearly indicate Y/N to all three consents:

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: / /

All 3 consent boxes above MUST be completed