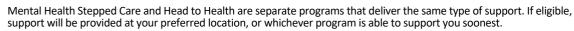
## Mental Health Stepped Care & Head to Health Referral Form





Date:	Consumer prefers to be seen at:						
	North East	Inner East	Outer East				
Please indicate if consumer presents with moderate risk of suicide  Eligibility Criteria (Must be completed)  Unable to afford or access a similar service (e.g. due to low income, lack of service availability  Resides or works/studies within the EMPHN catchment	Eltham (Health Ability)  Epping (Banyule CHS)  Greensborough (Banyule CHS)  Heidelberg West (Banyule CHS)  Kinglake (Nexus Primary Health)  Wallan (Nexus Primary Health)	Box Hill (HealthAbility) Doncaster East (Access Health & Community) Hawthorn (Access Health and Community)	Belgrave (Inspiro) Boronia (HealthAbility) Healesville (Oonah Belonging Place) Lilydale (Inspiro) Ringwood (Access Health & Community) Yarra Junction (Inspiro)				
	☐ Prefers phone / video	/ web-based support					
1. REFERRER DETAILS							
Referrer name:	Relationsh	nip to consumer:					
Organisation:							
Address:Email:							
Phone: Fax:							
2. CONSUMER DETAILS							
First Name:	Surname	<u>;</u>					
DOB: Gender: Phone:							
Address:							
Suburb: Postcode:							
Email:							
I do <b>NOT</b> consent for $\square$ sending mail to abo	ve address 🔲 leaving voice	messages on phone	receiving SMS				
Currently homeless: Yes No Comm	nents (incl. if at risk):						
Aboriginal Torres Strait Islander background Culturally and Linguistically Diverse Background							
Country of Birth: Interpreter Required (Language/Auslan):							
Mobility/Disability Needs:							
Income Source:							
NDIS: Has NDIS funding in place Comments:	Does not have NI	DIS funding in place					
3. EMERGENCY CONTACT If the consumer is a child, please write details	s of the parent or guardian w	ho is responsible for dec	isions about treatment.				
First Name:							
	tionship to Consumer:		_				

## 4. CLINICAL INFORMATION

Note: Only complete this section if this information has not been provided in attached documentation

Presenting issues:
Reason for referral:
Mental health diagnosis (if known):
Medication (if known):
Relevant medical history:
Substance use/Addictive behaviours:
Other impacting factors (including risk factors):

<u>Please attach any relevant/supporting documentation such as: Mental Health Treatment</u>
<u>Plan/Assessment notes/Outcome measures/Discharge summary</u>

## **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		Ye	s :				_
Current Suicidal Plan:		No		Ye	s:				_
Current Suicidal Intent:		No							_
Recent Suicide attempt in the	e last 1	three	months?		Yes	☐ No			
Relevant History:									_
Suicide Ri	sk Lev	el:	☐ Not A	Арра	arent	Low		☐ High	
Current Self Harm Thoughts:		No		Yes	s :				_
Current Self Harm Plan:		No		Yes	s:				_
Current Self Harm Intent:		No		Yes	s :				_
Current behaviours:									_
Relevant History:									_
Self-Harm Ri					parent	☐ Low		☐ High	
Current Harm to Others Tho	ıøhts	П	No	П	Vec ·				
Current Harm to Others Plan	-		No						_
Current Harm to Others Inte									_
Relevant History:	-		_		163.				
Risk to ot									_
KISK to ou	ners:		Not Ap	pare	ent	Low	Medium	High	
Risk of harm from others:		Yes		lo					
Comments:									

**Additional Comments:** 

## **CONSENT** - Must be completed and signed

Name: ...... D.O.B

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 improve mental health and alcohol and other drug 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 collect	tion and sharing of information	with other services:						
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 take part or not.  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.								
Consumer Signature: Date: / /								
<u>or</u>								
Referrer Signature (Verbal consent provided by consumer): Date:/								