Mental Health Services Referral Form

Date: _____

1. REFERRER DETAILS

Name: _____

GP /Psychiatrist Provider Number (where appropriate): _____

_____

Position and organisation: _____

_____

Phone: _____ Fax: _____

Address: _____

Suburb: _____ Postcode: _____

2. CLIENT DETAILS

First Name: _____ Surname: _____

DOB: _____ Gender: _____ Phone: _____

Address: _____

Suburb: _____ Postcode: _____

Aboriginal and /or Torres Strait Islander background: _____ Country of Birth: _____

Culturally and Linguistically Diverse Background: _____Interpreter Required (Language): _____

Next of Kin Name: _____ Relationship: _____ Phone: _____

Mental Health Diagnosis: _____

RISK ASSESSMENT (MUST BE COMPLETED)

If your client is presenting in an acute psychiatric crisis or risk is high please call your local area mental health service

Suicide Risk Level: ☐ **NOT APPARENT** ☐ **LOW** ☐ **MEDIUM** ☐ **HIGH**

Details of current Thoughts, Plan or Intent: _____

Recent Suicide attempt in the last three months: _____

Relevant History : _____

Self-Harm Risk Level: ☐ **NOT APPARENT** ☐ **LOW** ☐ **MEDIUM** ☐ **HIGH**

Current Thoughts, Plan or Intent: _____

Current behaviours: _____

Relevant History: _____

Harm to others: ☐ **NOT APPARENT** ☐ **LOW** ☐ **MEDIUM** ☐ **HIGH**

Current Thoughts, Plan or Intent: _____

Relevant History: _____

CURRENT RISK MANAGEMENT PLAN: _____

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

3. CONSENT

☐ Client/parent/guardian consents to the referral, transfer of referral documentation and consultation with appropriate service providers in regards to their ongoing care.

☐ Your client consents to their/ their child's de-identified information being used by EMPHN for evaluation and reporting purposes to the Department of Health. They understand this data, which does not include their name, address or Medicare number, but will include information such as date of birth, gender and types of services they use, will be used for the purposes of improving health services in Australia. Your client understands that their/ their child's information will not be provided to the Department of Health if they indicate they do not consent.

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

☐ **Psychological Strategies** (formerly known as ATAPS)
https://www.emphn.org.au/what-we-do/mental-health/psychological-strategies

Preferred provider/organisation:_____or EMPHN to select ☐
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: _____

☐ **Suicide Prevention Service**
https://www.emphn.org.au/what-we-do/mental-health/psychological-strategies

Preferred provider/ organisation:_____or EMPHN to select ☐
Eligibility criteria:

☐ Low to moderate risk of suicide and/or self-harm

☐ Not engaged with /appropriate for public mental health service

☐ Client has been provided with/referred to the All Hours Suicide Support Line - **1800 859 585** for after-hours support

☐ **Mental Health Nurse**
https://www.emphn.org.au/what-we-do/mental-health/mhnip

Preferred provider/organisation:_____or EMPHN to select ☐
Eligibility criteria:

☐ Has a mental health treatment plan ☐ Functional impairment

☐ Diagnosed mental health condition ☐ At risk of hospitalisation

☐ Requires medium to long term care ☐ Client not linked with public mental health service

☐ **Support Coordination** (Partners in Recovery)
https://www.emphn.org.au/what-we-do/mental-health/pir

Eligibility criteria:

☐ Appears to have severe and persistent mental health issues ☐ Needs support from multiple services

Comments: _____

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