

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 and for transfer of referral documentation to appropriate service providers.
- 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/suicide-prevention>

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/mhnp>

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: _____