Mental Health Stepped Care Referral Form

Date: _____

Eligibility Criteria (Must be completed)
☐ **Low Income** (*e.g. Health Care Card, Disability Support Pension, or no source of income)* Relevant card no. _____ and/or ☐ **Low to moderate suicide risk** *NB: Clients who present with low to moderate suicide risk do not need to meet low income criteria*
☐ **Medicare Card Holder** or ☐ **Asylum Seeker**
☐ **Client residing or working within EMPHN Catchment**

Client prefers to be seen at:
☐ **Banyule CHS** (Heidelberg West, Greensborough) ☐ **Banyule CHS – Whittlesea area** (Epping, Whittlesea, South Morang) ☐ **Health Ability** (Eltham) ☐ **Nexus Primary Health** (Wallan, Kinglake)
☐ **Prefers phone / video / web-based support**

1. REFERRER DETAILS

Referrer name: _____ Relationship to Client: _____

Organisation: _____

Address: _____

Suburb: _____ Postcode: _____

Phone: _____ Fax: _____

2. CLIENT DETAILS

First Name: _____ Surname: _____

DOB: _____ Gender: _____ Phone: _____

Email: _____

Address: _____

Suburb: _____ Postcode: _____

☐ Aboriginal ☐ Torres Strait Islander background ☐ Culturally and Linguistically Diverse Background

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

Income Source: _____ Mobility/Disability Needs: _____

Homelessness: ☐ Yes ☐ No Comments: _____

NDIS package approved: ☐ Yes ☐ No Comments: _____

3. EMERGENCY CONTACT

If the client is a child, please provide the details of the parent or guardian who is responsible for decisions about treatment.

First Name: _____ Surname: _____

Gender: _____ Relationship to Client: _____

Phone: _____ Email: _____

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

4. CONSENT

☐ Client / parent / guardian consents to Eastern Melbourne PHN (EMPHN) to seek, collect and share their relevant health information to the appropriate service provider(s) for the purpose of referral for ongoing care.

☐ Client / parent / guardian 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. Client understands that their/ their child's information will not be provided to the Department of Health if they indicate they do not consent.

Please list all health professionals involved in client's care and client/parent/guardian consent for EMPHN to contact them for the purposes of seeking collateral information: e.g. psychiatrist, GP, CAT team, allied health professionals etc.

	Name	Organisation	Contact details	Consent for contact
Please select			Phone: Fax:	Yes ☐ No ☐
Please Select			Phone: Fax:	Yes ☐ No ☐
Please select			Phone: Fax:	Yes ☐ No ☐
Please select			Phone: Fax:	Yes ☐ No ☐

Client Signature: ..... ☐ Or verbal consent provided **Date:** ...../...../.....

Referrer Signature: ..... **Date:** ...../...../.....

5. CLINICAL INFORMATION

Note: Only complete this section if this information has not been provided in a Treatment Plan

Presenting Issues:

Reason for Referral to Stepped Care:

Mental Health Diagnosis (if known):

Medication (if known):

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Relevant Medical History:
Substance Use:
Other Impacting factors:

Please attach any relevant/supporting documentation: Mental Health Care Plan, Assessment notes/Outcome measure/Discharge summary

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

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: _____

Risk to others: ☐ **Not Apparent** ☐ **Low** ☐ **Medium** ☐ **High**

CURRENT RISK MANAGEMENT PLAN

☐ **Yes,** date of plan: _____

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

☐ **N/A** Please comment: _____

Comments: _____

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