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phn EASTERN MELBOURNE
An Australian Government Initiative

Psychosocial Support Service Referral Form

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

Date

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:

Email:

Phone: | Fax:

2. CONSUMER DETAILS

First Name: | Surname:

DOB: | Gender: | Preferred Pronoun: | Phone:

Address:

Suburb: | Postcode:

Email:

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

Currently homeless: ☐ Yes ☐ No Comments (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: | Health Care Card Yes ☐ No ☐

NDIS

- ☐ Has NDIS funding in place
- ☐ Does not have NDIS funding in place
- ☐ 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)

Comments:

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

Reason for referral:

Mental health diagnosis (if known), presenting mental health need(s) and medications:

Current physical health diagnosis/presenting physical health need/s:

Mobility/Disability needs:

Addictive behaviours:

When considering the following areas, please detail any impacts to functioning as a result of their MH condition and identify any associated 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? ☐ No ☐ Yes

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:

Current behaviours?

Relevant history:

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

Risk of harm from others: ☐ No ☐ Yes

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 to support engagement:

CONSENT (MUST BE COMPLETED)

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.EMPHN is required to provide data to the Department of Health and Aged Care, and State and Territory Health Departments, outlining the services that have been provided to people that have accessed their funded services.
The Dept. are also seeking your consent to view your de-identified personal details (date of birth and gender), to support effective service funding and planning (these details do not include details such as your name, address or Medicare number). Please note that this consent can be changed at any time.

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.).

If consenting, please list who can be contacted:

Profession	Name	Organisation	Contact
			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 consents to the Dept. viewing your de-identified personal details as described above?

☐ 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: _____

Please fax completed form to F: 8677 9510; or
Secure email: supportconnect@emphn.org.au
For any queries, please call 9800 1071