CLICK HERE TO PRINT FORM

phn EASTERN MELBOURNE
Australian Government Initiative

Psychosocial Support Service Referral Form

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

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
- ☐ Has not been referred to/ is not currently being supported by another similar service

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 ☐ SMS

Identifies as LGBTQIA+: ☐ Yes ☐ No ☐ Unknown/prefer not to say

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:

Please identify consumer capacity building goals for psychosocial support and detail any impacts to functioning that are a result of MH condition

Managing daily activities and responsibilities (e.g. self care, cooking, parenting):

Consumer goal:

Current functioning:

Social skills, friendships and family relationships:

Consumer goal:

Current functioning:

Education/Employment:

Consumer goal:

Current functioning:

Physical wellbeing:

Consumer goal:

Current functioning:

Life skills (e.g. self confidence, resilience):

Consumer goal:

Current functioning:

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. Consent to share deidentified data with Department of Health and Aged Care (DoHAC):

EMPHN is required to provide service activity data to the Department of Health and Aged Care, and State and Territory Health Departments (the Depts.). This non personal data sharing does not require your consent and is used to understand the services provided by funded programs. These Depts. are seeking your consent to view additional information to further improve service planning and provision. They would like to view **de-identified** personal information such as date of birth, gender and postcode. This de-identified data can also be linked to other available de-identified data from other services. We will not share any identifiable information such as name, address or Medicare number. Do you consent to these Depts. viewing your de-identified personal details? Please note you can withdraw your consent 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 Depts. 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: _____

Medicare Mental Health facilitates service navigation on behalf of commissioned programs, including the Psychosocial Support Service

Please fax completed form to Medicare Mental Health on **8677 9510**

For any queries, please call **1800 595 212 (and enter the consumers postcode)**