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phn EASTERN MELBOURNE
An Australian Government Initiative

Mental Health Stepped Care & Head to Health Hub Referral Form

Mental Health Stepped Care and the Head to Health Hubs are separate services that deliver the same type of support. If eligible, support will be provided at your preferred location, or whichever program is able to support you soonest.

Date

Eligibility Criteria (must be completed)

- ☐ Presenting with a need for mental health support
- ☐ Unable to afford or access a similar service (e.g. due to low income, lack of service availability)
- ☐ Resides or works/studies within the EMPHN catchment

Consumer prefers to be seen at:

North East	Inner East	Outer East
☐ Epping (Holstep Health)	☐ Box Hill (healthAbility)	☐ Belgrave (Inspiro)
☐ Greensborough (Holstep Health)	☐ Doncaster East (Access Health & Community)	☐ Lilydale (Inspiro)
☐ Heidelberg West (Holstep Health)	☐ Hawthorn (Access Health and Community)	☐ Telehealth (healthAbility)

☐ Prefers phone / video / web-based support

1. REFERRER DETAILS

Referrer name: | Relationship to consumer:

Organisation:

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

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:

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

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. CLINICAL INFORMATION

Note: Only complete this section if this information has not been provided in attached documentation

Reason for referral:

Presenting issues: (consider symptom severity and distress and mental health diagnosis if relevant)

Impact on current functioning: (consider sleep, appetite, employment, self-care, usual responsibilities)

Co-existing conditions: (for example: substance use, physical health conditions and cognitive impairment)

Treatment and recovery history: (consider services, medication, therapies)

Current supports: (professional and personal)

Please list any other referrals made:

Additional information?

Please attach any relevant/supporting documentation such as:

Mental Health Treatment Plan/NDIS plan/Assessment notes/Outcome measures/Discharge summary

RISK ASSESSMENT (MUST BE COMPLETED)

If your consumer 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? ☐ 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

Comments (Please include/attach any risk management information or plans):

Any additional information to support your referral:

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 Stepped Care and Head to Health Hubs.

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

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