Mental Health Service Referral Form

HEAD TO HEALTH CAREinMIND™ phn NORTH WESTERN MELBOURNE An Australian Government Initiative

About NWMPHN mental health referral and access

1. The North Western Melbourne Primary Health Network (NWMPHN) mental health referral and access team is an entry point for eligible people seeking **primary mental health support in the NWMPHN region.**
2. Referrals are for people who are unable to access MBS subsidised or private mental health services.
3. Credentialled mental health clinicians will assess and allocate the referral to the most clinically appropriate service, and you will be informed of the outcome.
4. The client will be contacted directly by the service to schedule an appointment.
5. **For questions or referral support –** contact the mental health referral and access team on (**03) 9088 4277.**

Complete and fax this form to (03) 9348 0750 or send a password protected pdf to referralandaccess@nwmphn.org.au

How long will it take for my client to see a mental health professional? Clients generally have their first appointment with a mental health professional within 4 – 6 weeks of the PHN receiving the referral.

This is **NOT A CRISIS SERVICE**. If crisis support is required, please call **000** or your local emergency service.

Please note, services are restricted to people live work or study in the North Western Melbourne Primary Health area. Find your local PHN

PLEASE NOTE: * denotes mandatory information. If this information is not included, referral may be delayed or not accepted.

This form meets the minimum requirements for billing a Mental Health Treatment Plan (MHTP), therefore you are not required to attach a separate MHTP.

Referral Date*:		
REFERRAL ELIGIBILITY *		
If any of the below are ticked "yes", the client is eligible to access free mental health services.		
Is client experiencing severe financial hardship?	☐ No	☐ Yes
Reason for financial hardship: Provide short description of financial hardship: e.g. studying and no job or low or no income, disability support pension.		
Does client hold a Health Care Card (HCC) or similar?	☐ No	☐ Yes **Provide HCC number and expiry date:**
Is the client from one the following priority population groups? (Please tick all that apply)		
1. Homeless or at risk of becoming homeless?	☐ No	☐ Yes
2. Of Aboriginal and/or Torres Strait Islander origin?	Select an option	
3. A child (under the age of 18)?	☐ No	☐ Yes
4. Currently seeking asylum or has refugee status in Australia?	☐ No	☐ Yes
5. Speaks a language other than English at home? ☐ No	☐ Yes - **(specify):** **If yes, is an interpreter required?** ☐ No ☐ Yes	
6. Is an international student?	☐ No	☐ Yes
7. Identify as LGBTQ+?	Select one	
If all of the above questions have been answered as "no", consider contacting 1800 595 212 or referral to a private psychologist or psychiatrist where appropriate.		
8. Is client seeking a formal assessment for neurodevelopmental disorders or a report for matters relating to the justice system or mediation?	☐ No	☐ Yes – If yes, this referral is not eligible for NWMPHN mental health services.
CLIENT CONTACT INFORMATION*		
Name*: Preferred Name: Title: Choose an item First Name: Last Name:		

DOB*:	**Gender identity*:** Choose an item
Country of Birth:	
Phone*:	
Address* (include postcode):	
Email address:	

Parent/Guardian name and phone number (if client is under age 16) *

OR (for clients aged between 12 – 16 who are "mature minors")

☐ I have assessed the client as a "mature minor" and they understand the nature of the referral

☐ I have spoken to client about informing parent or guardian about mental health referral and there is a clear reason why the parents have not been informed. **If ticked, please reply reason:** Click or tap here to enter text.

RISK ASSESSMENT*	**No**	**Yes (If yes, provide details:)**
1. Is client currently at risk of harm from others?	☐ No	☐ Yes
2. Is client currently at risk of harm to others? (e.g. forensic history)	☐ No	☐ Yes
3. Is there evidence of self-harm?	☐ No	☐ Yes
4. Does client have suicidal thoughts?	☐ No	☐ Yes
5. Does client have suicidal intent?	☐ No	☐ Yes
6. Does client have a suicide plan?	☐ No	☐ Yes
7. Has client made a previous suicide attempt?	☐ No	☐ Yes **If yes, include details and indicate how long ago.**
Is the primary purpose of this referral to seek support to prevent suicide?	☐ No	☐ Yes **If yes, please fax to the suicide prevention intake on (03) 8080 8948.** **Clients with acute suicidality should be referred to Emergency Department or local Psychiatric Triage.**

REASON FOR REFERRAL*

Provide a reason for referral including a mental state examination and relevant history (biological, psychological, social) affecting the person being referred. More detail here will help the NWMPHN mental health access team refer to the most appropriate support:

Sessions required: Up to 12

CLIENT GOALS

Provide a description of the client's goals and related actions:

I have provided psychoeducation to the client ☐

ADDITIONAL INFORMATION

Does the client have a mental health diagnosis?	☐ No	☐ Yes **If yes, provide details on the diagnosis:**

Is the client prescribed medication for mental illness?	☐ No	☐ Yes **If yes, provide details of medication and dosage:**
Does client have other support services in place?	☐ No	☐ Yes **If yes, provide details on the other services and their involvement.**

K10 Score:	
IAR-DST Score: If you have completed at Initial Assessment and Referral Decision Support Tool, please add in the score here and/or attach the assessment with this form. **The IAR-DST can be completed at https://iar-dst.online/#/**	Select score 1–5
Other Measure:*(e.g. DASS-21, SDQ):*	*(score)*

REFERRER INFORMATION*	**GP INFORMATION (if not referrer)**
Referrer Name*:	**GP Name:**
Referrer Profession*:	**GP Organisation:**
Referrer Organisation*:	**Address:**
Address*:	**Postcode:**
Postcode*:	**Telephone:**
Telephone*:	**Fax:**
Fax*:	**Email:**
Email*:	

CLIENT CONSENT*

1. Consent to receive service and for sharing of service delivery information *

By signing this consent, you agree to **receive care** from the health provider who receives this referral and to share this information with that health provider.

☐ ***Yes, I (client) consent to share the information from our conversation today with health providers for the purposes of receiving care.***
☐ ***Yes, client has provided verbal consent.***
☐ ***No, I do not consent.***

2. Consent to share de-identified data with the Australian Government Department of Health and Aged Care (the Department), and independent evaluators *

To help improve this service, the Department needs to understand who is using it. They want to understand users' age, gender and location but not any personal details that can be linked back to you. Are you OK for us to share this information with the Department for evaluation of the service's use?

☐ ***Yes, I (client) consent to the sharing of some of my information with the funders of this service, the Department of Health, and independent evaluators engaged by them.***
☐ ***Yes, client has provided verbal consent.***
☐ ***No, I do not consent.***

3. Experience of service survey and evaluation of NWMPHN commissioned mental health services *

We would like to know about your experience of the mental health service you are referred to. A survey will be sent that you can choose to complete. Are you OK for us to use your email or mobile phone number to send you a link to the survey?

☐ ***Yes, I (client) consent to being contacted to participate in the evaluation of the service I receive. I agree that my contact details may be disclosed to the contracted evaluation provider for that purpose.***

☐ ***Yes, client has provided verbal consent.***
☐ ***No, I do not consent.***