Mental HealthTriage Referral Form

REFERRAL FORM

T: 1300 782 391 | **F:** 02 8072 6899

CRITERIA

For referral to **short-term psychological therapies**, please confirm the following (must check both items to be eligible)

- ☐ Patient is unable to access Medicare rebated (Better Access) psychological services OR cannot afford the gap payment under Medicare (e.g. on low income or pension)
- ☐ Mental Health Treatment Plan and outcome measure attached

PATIENT DETAILS

Name:

Address: **Postcode:**

Date of birth: **Gender:** ◯ M ◯ F ◯ Other ◯ Unstated

Phone contact: **Country of birth:**

Main language spoken at home:

Spoken English level: ◯ Very well ◯ Well ◯ Not very well ◯ Not at all ☐ **Interpreter Required**

Indigenous status: ◯ Aboriginal ◯ Torres Strait Islander ◯ Both ◯ Neither

Homelessness: ◯ Not homeless ◯ Short term/Emergency accomodation ◯ Sleeping rough

Employment status: ◯ Employed ◯ Unemployed ◯ Not in labour force ◯ Unknown

NDIS participant: ◯ Yes ◯ No ◯ Unknown **Health care card:** ◯ Yes ◯ No

MENTAL HEALTH PRESENTATIONS

Suicide prevention referral: ◯ No ◯ Yes ◯ Attempted ◯ At risk of suicide

If person is at immediate risk (intent or plan), contact the *Mental Health Access Line: 1800 011 511*

Presenting issues: ☐ See Mental Health Treatment Plan

Principal diagnosis:

ANXIETY DISORDERS
- ☐ Stress related
- ☐ Panic disorder
- ☐ Social phobia
- ☐ Generalised anxiety (GAD)
- ☐ Obsessive Compulsive Disorder
- ☐ Post Traumatic Stress Disorder

AFFECTIVE/MOOD DISORDERS
- ☐ Major depression
- ☐ Adjustment disorder
- ☐ Depressive symptoms
- ☐ Bipolar disorder

PSYCHOTIC DISORDERS
- ☐ Schizophrenia
- ☐ Eating disorder
- ☐ Personality disorder

CHILDHOOD / ADOLESCENCE
- ☐ Adjustment disorder
- ☐ Oppositional defiant disorder
- ☐ Conduct disorder
- ☐ ADHD - Attention deficit hyperactivity disorder

SUBSTANCE USE DISORDERS
- ☐ Alcohol dependance
- ☐ Other drug dependence

OTHER
- ☐ Other mental disorder

Severity: ◯ Mild ◯ Moderate ◯ **Severe:** ◯ Acute OR ◯ Complex

Psychotropic medication: *(Tick all that apply)*
- ☐ None
- ☐ Hypnotics and sedatives
- ☐ Psychostimulants and nootropics
- ☐ Antidepressants
- ☐ Antipsychotics
- ☐ Anxiolytics

Outcome tool score: *(Attach form)*
- ☐ K10+: _____
- ☐ K5: _____
- ☐ SDQ: _____
- ☐ Other: _____

Previous Mental Health history or treatment: ☐ See attached Mental Health Treatment Plan

Physical health conditions to note:

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PRIORITY GROUP

Underserviced group:

- ☐ Young person (12-25 yrs)
- ☐ Child (0-11 yrs)
- ☐ Aboriginal and/or Torres Strait Islander
- ☐ Carer
- ☐ Culturally and linguistically diverse
- ☐ Peri-natal
- ☐ Lesbian, gay, bisexual, trans, and/or intersex

SERVICES REQUESTED

Referred for which services:

- ☐ Short-term individual psychological therapies
- ☐ Short-term group psychological therapies
- ☐ Low intensity psychological interventions
- ☐ Support services following a suicide attempt
- ☐ Clinical care coordination for Severe and Complex Mental Illness
- ☐ Alcohol and drugs counselling
- ☐ Eating disorder services
- ☐ Indigenous specific services
- ☐ Other: _____

Preferred provider or service:
(Select from the list of PA+ providers in the Resources section of our webpage)

- ☐ No preference *(Provider/service will be assigned)*

ADDITIONAL INFORMATION

EMERGENCY CONTACT INFORMATION (e.g. parent, carer, spouse)

Name:	**Phone contact:**
Relationship:	**Email:**

REFERRER DETAILS

Name:	**Date:**
Profession:	**Service name:**
Phone contact:	**Fax number:**
Address:	**Email:**
	Postcode:

CONSENT - Patient or parent/guardian for a child

Patient has been informed of the role and services that SNPHN provides and understands that the information provided in this referral is required to determine eligibility for services. Patient gives consent for services to be provided by suitable SNPHN-commissioned providers, as requested on this referral. Patient gives permission for the exchange of this information between GP, SNPHN Mental Health Triage staff, Commissioned Service Provider, allocated health professional and other agencies for the purpose of coordination of care.

☐ Patient consent provided

REFERRALS FOR SHORT-TERM PSYCHOLOGICAL THERAPIES ONLY

☐ **Patient may be referred under the Better Access to Mental Health Services, if practitioner will bulk bill AND I have lodged an MBS item 2700/2701/2715/2717**

PLEASE ENSURE THE FOLLOWING BEFORE SENDING TO SNPHN:

- ☐ Patient details are correct (including contact information)
- ☐ Patient has consented to the referral
- ☐ MHTP & Outcome measure is attached *(ONLY for short term psychological and group therapies)*

Send completed forms via Secure Fax (02) 8072 6899

CLEAR FORM PRINT FORM