Mental Health Triage

REFERRAL FORM

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

Submit referrals via your secure messaging service or secure fax.

PLEASE SUBMIT REFERRALS via your secure messaging service or secure fax to **02 8072 6899**. If you need help completing the referral or have any questions, please phone **1300 782 391** in business hours (9.00am to 5.00pm Monday to Friday).

THIS IS NOT A CRISIS SERVICE, if urgent emergency care is required, please call 000 or the NSW Mental Health Line on 1800 011 511.

If Patient is at risk of suicide: ***please give after-hours Suicide Support Line 1800 859 585.***

REFERRER DETAILS		Date of Referral:		
First Name:		Last Name:		
Referrer Type:	☐ GP ☐ Paediatrician ☐ Psychiatrist ☐ Other:			
Organisation/ Practice:				
Street Address:				
Suburb:		Postcode:		State:
Provider No.:		Fax:		
Daytime Phone:		Email:		
Consent to referral:	☐ GP confirms that the patient understands and consents to the referral and has received a Client Information Sheet			

For referral to **short-term psychological therapies**, does patient meet **SNPHN Criteria? (must check <u>each</u> item to be eligible)**

- ☐ Patient lives, works or attends school in the SNPHN region
- ☐ Patient is unable to access Medicare rebated (Better Access) psychological services OR cannot afford the gap payment under Medicare
- ☐ Patient is unable to access other available services and has not accessed Better Access in this calendar year
- ☐ Mental Health Treatment Plan and outcome measure attached

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PATIENT DETAILS

First Name:		Last Name:	
Date of Birth:		Gender:	◯ M ◯ F ◯ Other ◯ Unstated
Street Address:		Email:	
Suburb:		Post Code:	
Mobile:		Home Phone:	

PATIENT DETAILS

Aboriginal:	◯ Yes ◯ No	Torres Strait Islander:	◯ Yes ◯ No
Country of birth:		Main language spoken at home:	
Speaks English:	◯ Very well ◯ Well ◯ Not very well ◯ Not at all ◯ N/A (e.g. < 5 years old)		
Translator/Assistance:	◯ No assistance required ◯ Translator Required ◯ Other:		
Marital Status:	◯ Married/De Facto ◯ Separated ◯ Divorced ◯ Widowed ◯ Never Married		
Employment Status:	◯ Full-time ◯ Part-time ◯ Not applicable - not in the labour force		
Does the person have a health care card?	◯ Yes ◯ No ◯ Not Known	Is the person under financial hardship?	☐ Limited Cash Income ☐ Significant Financial Hardship
What is the source of the person's cash income?	☐ Paid employment ☐ Other (Super, Investments) ☐ Nil income	☐ Compensation payments ☐ Other pension or benefit ☐ Not Known	☐ Disability Support Pension **Has the person accessed the NDIS?** ◯ Yes ◯ No
Are they homeless?	◯ Not Homeless ◯ Sleeping rough / unstable accommodation ◯ Short Term or emergency		
Is the client part of an underserviced group?	☐ Woman experiencing perinatal depression/anxiety	☐ Child (0-11yrs) ☐ Young person (12-25yrs)	☐ LGBTI ☐ Other:

PRIMARY DIAGNOSIS & CLINICAL INFORMATION

Primary Mental Health Diagnosis:		Current Medications:	
Suicidality: *If answer is 'Yes' to plan or intent, refer to Mental Health Access Line: 1800 011 511*	☐ Suicidal thoughts ☐ Suicidal intent ☐ Suicidal plan ☐ Recent suicide attempt	Current Medication Classes:	☐ Antidepressants ☐ Anxiolytics ☐ Hypnotics and sedatives ☐ Antipsychotics ☐ Psychostimulants and nootropics

ADDITIONAL CO-EXISTING DIAGNOSES

ANXIETY DISORDERS
- ☐ Stress related
- ☐ Anxiety symptoms
- ☐ Panic disorder
- ☐ Agoraphobia
- ☐ Social phobia
- ☐ Generalised anxiety (GAD)
- ☐ Obsessive Compulsive Disorder
- ☐ PTSD
- ☐ Acute stress disorder
- ☐ Other anxiety disorder

AFFECTIVE/MOOD DISORDERS
- ☐ Depressive symptoms
- ☐ Adjustment disorder
- ☐ Major depressive disorder
- ☐ Dysthymia
- ☐ Depressive disorder NOS
- ☐ Bipolar disorder
- ☐ Cyclothymic disorder
- ☐ Mixed anxiety and depressive symptoms
- ☐ Other affective disorder

PSYCHOTIC DISORDERS
- ☐ Schizophrenia
- ☐ Schizoaffective disorder
- ☐ Brief psychotic disorder
- ☐ Other psychotic disorder
- ☐ Eating disorder
- ☐ Somatoform disorder
- ☐ Personality disorder

SUBSTANCE USE DISORDERS
- ☐ Alcohol harmful use
- ☐ Alcohol dependence
- ☐ Other drug harmful use
- ☐ Other drug dependence
- ☐ Other substance use disorder

CHILDHOOD / ADOLESCENCE
- ☐ Separation anxiety disorder
- ☐ ADHD - Attention deficit hyperactivity disorder
- ☐ Conduct disorder
- ☐ Oppositional defiant disorder
- ☐ Pervasive developmental disorder
- ☐ Other disorder of childhood and adolescence

OTHER
- ☐ Other mental disorder
- ☐ Other

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SEVERITY OF MENTAL ILLNESS / ADDICTION & REFERRAL RECOMMENDATIONS

☐ **MILD (SHORT TERM TREATMENT)**
Some symptoms or those at risk of mental illness. Limited effect on daily functions (social, personal, family and occupation).

☐ Low intensity psychological interventions (telephone coaching & guided self-help)

☐ **MODERATE (SHORT TERM TREATMENT)**
More symptoms impacting on daily functions (social, personal, family and occupation) more than usual.

☐ Individual Psychological Therapy

☐ Group Psychological Therapy

☐ **SEVERE (LONGER TERM TREATMENT)**
Severe level of symptoms which significantly impact on daily functions (social, personal, family and occupation).

☐ Clinical care coordination and case management

SPECIALISED SERVICE REQUESTED

☐ Youth-specific mental health services
☐ Indigenous-specific mental health services
☐ LGBTI-specialist addiction services
☐ Psychological therapies for people of Chinese background
☐ Non-residential addiction rehabilitation services
☐ NON-ACUTE Therapy for Suicidal Ideation
☐ NON-ACUTE Care Services following a Suicide Attempt

ANY CURRENT SERVICES INVOLVED IN CARE (attach additional sheet if necessary)

Agency	Service Type	Record contact details or other relevant info

PREFERRED PROVIDER (IF APPLICABLE)

First Name:		Last Name:	
Organisation/ Practice:		Most Recent PIN (if Applicable)	
Daytime Phone:		Fax:	
Email:		Other information:	

EMERGENCY CONTACT INFORMATION

Who does the patient nominate to be a contact to communicate with to support the patient (if needed)?

Name:		Daytime Phone:	
Relationship:		Email:	

OTHER NOTES

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K10+ MENTAL HEALTH SELF ASSESSMENT (FOR PEOPLE 16+)

First Name:		Last Name:	
Date of Birth:		**TODAY'S DATE:**	

Instructions: The following questions ask about how you have been feeling in the last four weeks. For each question, mark the circle under the option that best describes the amount of time you felt that way.

In the last 4 weeks:	**None of the time 1**	**A little of the time 2**	**Some of the time 3**	**Most of the time 4**	**All of the time 5**
1. About how often did you feel tired out for no good reason?	○	○	○	○	○
2. About how often did you feel nervous?	○	○	○	○	○
3. About how often did you feel so nervous that nothing could calm you down?	○	○	○	○	○
4. About how often did you feel hopeless?	○	○	○	○	○
5. About how often did you feel restless or fidgety?	○	○	○	○	○
6. About how often did you feel so restless you could not sit still?	○	○	○	○	○
7. About how often did you feel depressed?	○	○	○	○	○
8. About how often did you feel that everything was an effort?	○	○	○	○	○
9. About how often did you feel so sad that nothing could cheer you up?	○	○	○	○	○
10. About how often did you feel worthless?	○	○	○	○	○
			TOTAL SCORE:		
11. How many days were you totally unable to work, study or manage your day to day activities because of these feelings?					Number of days
12. Aside from those days, in the past four weeks, how many days were you able to work or study or manage your day to day activities, but had to cut down on what you did because of these feelings?					Number of days
13. How many times have you seen a doctor or any other health professional about these feelings?					Number of consultations
14. How often have physical health problems been the main cause of these feelings?	○	○	○	○	○

SCORING
The K10 Total score is based on the sum of K10 item 01 through 10 (range: 10-50). Items 11 through 14 are excluded from the total because they are separate measures of disability associated with the problems referred to in the preceding ten items. The Total score is computed as the sum of the scores for items 1 to 10.

GP MENTAL HEALTH TREATMENT PLAN

PATIENT ASSESSMENT	
PATIENT NAME:	
DATE OF BIRTH:	
PRESENTING ISSUE(S): What are the patient's current mental health issues?	
CURRENT SITUATION: Predisposing factors, precipitating factors, stressors Symptom onset, duration, intensity, time course	
PATIENT HISTORY: Record relevant physical and mental health history	
FAMILY HISTORY: Mental Illness History of suicide	
SOCIAL SUPPORT: Social history, family contact and support including living arrangements, occupation	

GP MENTAL HEALTH TREATMENT PLAN (CONTINUED)

MEDICATIONS: Current and past medications and any side effects	
ALLERGIES:	
MENTAL STATE EXAMINATION: Consider appearance, cognition, thought process, thought content, attention, memory, insight, behaviour, speech, mood and affect, perception, judgement, orientation	
RISK ASSESSMENT: Consider suicidal thoughts, ideation, self-harm and risk of harm to others	Suicidal Thoughts: ◯ Yes ◯ No Suicidal Intent: ◯ Yes ◯ No Current Plan: ◯ Yes ◯ No Risk to Others: ◯ Yes ◯ No **If answer is 'yes' to plan, intent or risk to others, refer to Mental Health Access Line: 1800 011 511**
OUTCOME TOOL: Tool used and results	
DIAGNOSIS: May be provisional	
ANY OTHER COMMENTS:	

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MENTAL HEALTH TREATMENT PLAN

PATIENT PLAN			
Patient Name:		Date of birth:	
PATIENT NEEDS / MAIN ISSUES	**GOALS** Record the mental health goals agreed to by the patient and GP and any actions the patient will need to take	**TREATMENTS** Treatments, actions and support services to achieve patient goals	**REFERRALS** Note: Referrals to be provided by GP, as required, in up to two groups of six sessions. The need for the second group of sessions to be reviewed after the initial six sessions.
CRISIS / RELAPSE If required, note the arrangements for crisis intervention and/or relapse prevention			

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MENTAL HEALTH TREATMENT PLAN (CONTINUED)

APPROPRIATE PSYCHO-EDUCATION PROVIDED	PLAN ADDED TO THE PATIENT'S RECORDS	COPY (OR PARTS) OF THE PLAN OFFERED TO OTHER PROVIDERS
◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No ◯ Not required

PATIENT PREFERRED PROVIDER: (SUBJECT TO AVAILABILITY AND MAY BE LEFT BLANK)

1.

2.

COMPLETING THE PLAN

On completion of the plan, the GP is to record that s/he has discussed with the patient:

- The assessment;
- All aspects of the plan and the agreed date for review; and
- Offered a copy of the plan to the patient and/or their carer (if agreed by patient)

GP SIGNATURE

DATE PLAN COMPLETED	**REVIEW DATE** (initial review 4 weeks to 6 months after completion of plan)
REVIEW COMMENTS (Progress on actions and tasks)	**OUTCOME TOOL** **RESULTS ON REVIEW**

01 Jul 17