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