

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 each 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

REFERRAL FORM

T: 1300 782 391 | F: 02 8072 6899

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 underserved 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: <i>If answer is 'Yes' to plan or intent, refer to Mental Health Access Line: 1800 011 511</i>	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

<p>ANXIETY DISORDERS</p> <ul style="list-style-type: none"> Stress related Anxiety symptoms Panic disorder Agoraphobia Social phobia Generalised anxiety (GAD) Obsessive Compulsive Disorder PTSD Acute stress disorder Other anxiety disorder 	<p>AFFECTIVE/MOOD DISORDERS</p> <ul style="list-style-type: none"> Depressive symptoms Adjustment disorder Major depressive disorder Dysthymia Depressive disorder NOS Bipolar disorder Cyclothymic disorder Mixed anxiety and depressive symptoms Other affective disorder 	<p>PSYCHOTIC DISORDERS</p> <ul style="list-style-type: none"> Schizophrenia Schizoaffective disorder Brief psychotic disorder Other psychotic disorder Eating disorder Somatoform disorder Personality disorder <p>SUBSTANCE USE DISORDERS</p> <ul style="list-style-type: none"> Alcohol harmful use Alcohol dependence Other drug harmful use Other drug dependence Other substance use disorder 	<p>CHILDHOOD / ADOLESCENCE</p> <ul style="list-style-type: none"> Separation anxiety disorder ADHD - Attention deficit hyperactivity disorder Conduct disorder Oppositional defiant disorder Pervasive developmental disorder Other disorder of childhood and adolescence <p>OTHER</p> <ul style="list-style-type: none"> Other mental disorder Other
---	---	--	---

REFERRAL FORM

T: 1300 782 391 | F: 02 8072 6899

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