

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

SERVICES REQUESTED

Referred for which services:	Short-term individual psychological therapies	Clinical care coordination for Severe and Complex Mental Illness
	Short-term group psychological therapies	Alcohol and drugs counselling
	Low intensity psychological interventions	Eating disorder services
	Support services following a suicide attempt	Indigenous specific services
		Other: _____
Preferred provider or service: <i>(Select from the list of PA+ providers in the Resources section of our webpage)</i>	No preference <i>(Provider/service will be assigned)</i>	

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