



# PMHC Referral Form

Patient Information:			
Name			
Address			Postcode
Gender	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:	Phone Number:
Medicare Number			Country of Birth:
Main Language spoken at home	<input type="checkbox"/> English <input type="checkbox"/> Arabic <input type="checkbox"/> Cantonese <input type="checkbox"/> Mandarin <input type="checkbox"/> Hindi <input type="checkbox"/> Spanish <input type="checkbox"/> Italian <input type="checkbox"/> Other (please specify):		
Spoken English Level	<input type="checkbox"/> Very Well <input type="checkbox"/> Well <input type="checkbox"/> Not Well <input type="checkbox"/> Not at all		<input type="checkbox"/> Interpreter Required
ATSI	<input type="checkbox"/> Yes, Aboriginal <input type="checkbox"/> Yes, Torres Strait Islander <input type="checkbox"/> Yes, both <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Marital Status	<input type="checkbox"/> Never married <input type="checkbox"/> Married/De facto <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Unknown		
Homelessness	<input type="checkbox"/> Not homeless <input type="checkbox"/> Short-term/emergency accommodation <input type="checkbox"/> Sleeping rough		
Labour force status	<input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Not in the labour force <input type="checkbox"/> Unknown		
Employment type	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown		
Source of income	<input type="checkbox"/> Paid employment <input type="checkbox"/> Nil income <input type="checkbox"/> Disability support pension <input type="checkbox"/> Other pension <input type="checkbox"/> Not Applicable – Client under 16 <input type="checkbox"/> Compensation payments <input type="checkbox"/> Other (super, investments etc) <input type="checkbox"/> Unknown		
Health Care Card	Number:	<input type="checkbox"/> No <input type="checkbox"/> Unknown	
NDIS Registered	<input type="checkbox"/> No <input type="checkbox"/> Yes	Number:	<input type="checkbox"/> Unknown

Mental Health Presentations			
Presenting Issues:	<input type="checkbox"/> See attached Mental Health Treatment Plan		
<b>Principal Diagnosis</b>			
Anxiety Disorders:	<input type="checkbox"/> OCD	<input type="checkbox"/> Adjustment disorder	<input type="checkbox"/> Alcohol dependence
<input type="checkbox"/> Panic disorder	Depressive Disorders:	<input type="checkbox"/> Oppositional defiant	<input type="checkbox"/> Other drug dependence
<input type="checkbox"/> Agoraphobia	<input type="checkbox"/> Major depression	<input type="checkbox"/> Personality disorder	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Social phobia	<input type="checkbox"/> Depressive symptoms	<input type="checkbox"/> Conduct disorder	<input type="checkbox"/> Other:
<input type="checkbox"/> Generalised anxiety	<input type="checkbox"/> Bipolar Disorder		
Severity	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate	Severe:	<input type="checkbox"/> Acute or <input type="checkbox"/> Complex
Psychotropic Medication (please tick all that apply)	<input type="checkbox"/> None	<input type="checkbox"/> Antidepressants	
	<input type="checkbox"/> Hypnotics & sedatives	<input type="checkbox"/> Antipsychotics	
	<input type="checkbox"/> Psychostimulants & nootropics	<input type="checkbox"/> Anxiolytics	
Outcome Tool Score:	<input type="checkbox"/> K10 <input type="checkbox"/> K5 <input type="checkbox"/> SDQ	<input type="checkbox"/> Other _____	
	(Please attach form)		
Previous Mental Health History or Treatment:	<input type="checkbox"/> See attached Mental Health Treatment Plan		
<b>Physical Health Conditions to Note:</b>			

Priority Group	
Suicide Prevention Referral: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Child (0-12 years) <input type="checkbox"/> Young Person (13-25 years) <input type="checkbox"/> Aboriginal and/or Torres Strait Islander <input type="checkbox"/> Severe & Complex Mental Illness	
Vulnerable Group: <input type="checkbox"/> CALD <input type="checkbox"/> Peri-natal <input type="checkbox"/> LGBTIQ <input type="checkbox"/> Elderly <input type="checkbox"/> Refugee/Asylum Seeker	
Treatments	
Referred for which strategies	<input type="checkbox"/> Psychological therapy <input type="checkbox"/> Clinical care coordination <input type="checkbox"/> Low intensity psychological interventions <input type="checkbox"/> Complex care package <input type="checkbox"/> Child and youth specific services <input type="checkbox"/> Other: _____ <input type="checkbox"/> Indigenous specific services
Preferred Provider Or Service (Refer to Website)	<input type="checkbox"/> No Preference (Provider/service will be assigned by WW clinician)
Additional Information	

Referrer Details :			
Name		Profession	
Organisation type		Phone Number	
Address		Fax Number	
		Postcode	
REFERRER SIGNATURE		DATE	

CONSENT – Patient or Parent/guardian for a Child	
<p><i>I have been informed of the role and services that WentWest provides and I understand that the information provided in this referral is required to determine my eligibility for services. I give my consent for services to be provided by suitable WentWest programs, as requested on this referral. I give permission for the exchange of this information between my GP, Allied Health Professionals, and other agencies for the purpose of coordination of care.</i></p>	<p>Signature: _____</p> <p>Date: _____</p>

<p><b>Please ensure the following is complete before sending to WentWest:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Patient contact information including phone number</li> <li><input type="checkbox"/> Financial and priority group information including HCC number</li> <li><input type="checkbox"/> Referrer and patient signatures</li> <li><input type="checkbox"/> MHTP &amp; Outcome tool is attached</li> </ul> <p><b>Send completed form and MENTAL HEALTH TREATMENT PLAN via Secure Fax (02) 8208 9941</b></p>
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