PMHC Referral Form

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

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

Priority Group		
Suicide Prevention Referral: ☐ Yes ☐ No		
☐ Child (0-12 years) ☐ Young Person (13-25 years) ☐ Aboriginal and/or Torres Strait Islander ☐ Severe & Complex Mental Illness Vulnerable Group: ☐ CALD ☐ Peri-natal ☐ LGBTIQ ☐ Elderly ☐ Refugee/Asylum Seeker		
Treatments		
Referred for which strategies	☐ Psychological therapy ☐ Low intensity psychological interventions ☐ Child and youth specific services ☐ Indigenous specific services	☐ Clinical care coordination ☐ Complex care package ☐ Other:_____
Preferred Provider Or Service (Refer to Website)		☐ 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	
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.	Signature:_____ Date: _____

Please ensure the following is complete before sending to WentWest:

- ❑ **Patient contact information including phone number**
- ❑ **Financial and priority group information including HCC number**
- ❑ **Referrer and patient signatures**
- ❑ **MHTP & Outcome tool is attached**

Send completed form and MENTAL HEALTH TREATMENT PLAN via Secure Fax (02) 8208 9941

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