# Mental Health Referral Form

Secure Fax: **(02) 8208 9941** or HealthLink EDI: **wntwstmh**

**Please ensure the following is complete, it will not be triaged if mandatory requirements are not met:**

| **Mandatory requirements:** | **Psychiatry requirements:** |
|---|---|
| ☐ Health care card or evidence of low income | ☐ GP letter to psychiatrist (stating need) |
| ☐ Lives, works or studies in Western Sydney | ☐ Medication list |
| ☐ Mental Health Treatment Plan + completed K10, K5 or SDQ | ☐ No assessment needed for ASD/ADHD |
| ☐ DOES NOT need a crisis service or case management | |
| ☐ DOES NOT need support with legal or insurance matters | |

To support clinical assessment, please use the Initial Assessment and Referral Decision Support Tool (IAR-DST).

**Patient Information:**

| | | | | | |
|---|---|---|---|---|---|
| **Full Name:** | | | | **D.O.B:** | |
| **Address:** | | **Suburb:** | | **Postcode:** | |
| **Email:** | | **Mobile Number:** | | | |
| **Sex:** | ☐ M ☐ F ☐ Intersex ☐ Other: _____<br>Preferred pronoun: _____ | **Country of Birth:** | | | |
| **Main Language Spoken at Home:** | ☐ English<br>☐ Other: _____ | **Interpreter Required:** ☐ Yes ☐ No | | | |
| **Spoken English Level:** | ☐ Very well ☐ Well ☐ Not well ☐ Not at all ☐ Not applicable | | | | |
| **Aboriginal and/or Torres Strait Islander:** | ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Both ☐ Unknown | | | | |
| **Marital Status:** | ☐ Never married ☐ Married/De facto ☐ Widowed ☐ Divorced ☐ Separated ☐ Unknown | | | | |
| **Living Status:** | ☐ Stable housing ☐ Short-term/emergency accommodation ☐ Sleeping rough | | | | |
| **Labour Force Status:** | ☐ Employed ☐ Unemployed ☐ Not in the labour force ☐ Unknown | | | | |
| **Employment Type:** | ☐ Full-time ☐ Part-time/Casual ☐ Not applicable ☐ Unknown | | | | |
| **Source of Income:** | ☐ Paid employment ☐ Nil income ☐ Disability support pension ☐ Other pension<br>☐ Compensation payments ☐ Other (super, investments, etc.) ☐ Unknown | | | | |
| **Priority Group:** | ☐ CALD ☐ ATSI ☐ LGBTQIA+ ☐ Refugee/Asylum seeker ☐ Disability ☐ Perinatal<br>☐ Young Person | | | | |
| **Pension Card:** | ☐ No ☐ Yes | **DVA Card:** ☐ No ☐ Yes | | **NDIS Registered:** ☐ No ☐ Yes | |
| **Health Care Card:** | ☐ No ☐ Yes, number: _____ | | | **Access Requirements:** _____ | |

**Mental Health Presentations:** *(Previous Mental or Physical Health History or Treatment)*

**Principal Diagnosis:** ***(Please select one)***

Anxiety disorders:
- ☐ Panic disorder
- ☐ Agoraphobia
- ☐ Social phobia
- ☐ Generalised anxiety

- ☐ OCD

Depressive disorders:
- ☐ Major depression
- ☐ Depressive symptoms
- ☐ Bipolar disorder
- ☐ Adjustment disorder
- ☐ Oppositional defiant
- ☐ Personality disorder
- ☐ Conduct disorder
- ☐ Complex PTSD
- ☐ Alcohol dependence
- ☐ Drug dependence
- ☐ Schizophrenia
- ☐ Other: _____

Additional Diagnosis: _____

**Severity:** *(Please tick one)* ☐ Mild ☐ Moderate ☐ Severe Acute ☐ Severe Complex

**Is this person at high risk of suicide?** ☐ No ☐ Yes

| | | |
|---|---|---|
| **Psychotropic Medication:** | ☐ None<br>☐ Hypnotics and sedatives<br>☐ Psychostimulants and nootropics | ☐ Antidepressants<br>☐ Antipsychotics<br>☐ Anxiolytics |

| **Treatments:** | | |
|---|---|---|
| **Referred for which strategies:** | ☐ Psychological therapy<br>☐ Suicide prevention service | ☐ Psychiatric services<br>☐ Other:_____ |
| **Preferred WentWest Provider:** | ☐ Yes (provider name):_____<br>☐ No preference (provider/service will be assigned by WentWest) | |
| **Preferred Modality:** | ☐ Face-to-face, preferred location: _____ | ☐ Telehealth |

**Additional Information e.g. situational stressors or comorbidities**

| **Referrer Details:** | | | |
|---|---|---|---|
| **Full Name:** | | **Profession:** | |
| **Organisation Type:** | | **Phone Number:** | |
| **Address:** | | **Fax Number:** | |
| | | **HealthLink EDI:** | |

*****Consent: Patient or Parent/Guardian for a Child Must Complete for the Referral to be Accepted*****

☐ **Referrer confirms that they have read out the following and that the patient understands and consents to the following in accordance with the Privacy Act 1988:**

- Understands that the information provided is required to determine eligibility for services with Western Sydney Primary Health Network
- Gives consent for services to be provided by suitable programs, as requested on this referral
- Gives permission for the exchange of this information between health professionals and other agencies for the purpose of coordination of care and to best support the consumer seeking treatment
- Confirms in acknowledgment of referral, consents to them or their next of kin being contacted to organise treatment

| **Details of Emergency Contact/Next of Kin/Trusted Support:** | |
|---|---|
| **Full Name:** | |
| **Mobile Number:** | |
| **Relationship to the Patient:** | |

*****Please ensure the following is complete before sending to Western Sydney Primary Health Network*****

☐ **Referrer confirms that they have read out the following and that the patient understands and consents to the following in accordance with the Privacy Act 1988:**

- Gives permission to have de-identified information shared with the Department of Health and Aged Care and NSW Ministry of Health to be used for statistical linkage and evaluation purposes designed to improve mental health services in Australia
- Gives permission to have de-identified information shared with Western Sydney Primary Health Network for project evaluation and quality improvement purposes and agrees to be offered an experience of service survey
- Has the right to withdraw consent at any time

**Signature: _____** **Date: _____**

(Include name for forms sent via HealthLink)

**Send the completed form and Mental Health Treatment Plan via:**

Secure Fax: **(02) 8208 9941** or HealthLink EDI: **wntwstmh**

Please note: The Primary Mental Health Care team does not routinely accept referrals for the sole purpose of court reports and/or legal documentation.

# Outcomes Tool K10 Form

Name: _____

Date: _____

For all questions, please select the appropriate response.

| In the past 4 weeks: | None of the time | A little of the time | Some of the time | Most of the time | All of the time |
|---|---|---|---|---|---|
| About how often did you feel tired out for no good reason? | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| About how often did you feel nervous? | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| About how often did you feel so nervous that nothing could calm you down? | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| About how often did you feel hopeless? | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| About how often did you feel restless or fidgety? | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| About how often did you feel so restless you could not sit still? | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| About how often did you feel depressed? | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| About how often did you feel that everything is an effort? | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| About how often did you feel so sad that nothing could cheer you up? | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| About how often did you feel worthless? | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |

| **K10 Total Score** | |
|---|---|

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