Mental Health Referral Form

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

Patient Information:					
Full Name:				**D.O.B:**	
Address:		**Suburb:**		**Postcode:**	
Gender:	☐ M ☐ F ☐ Other:	**Country of Birth:**			
Medicare Number:		☐ Interpreter Required			
Main Language Spoken at Home:	☐ English ☐ Other (please specify):				
Spoken English Level:	☐ Very Well ☐ Well ☐ Not Well ☐ Not at all				
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				
Homelessness:	☐ 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 ☐ Compensation payments ☐ Other (super, investments etc.) ☐ Unknown				
Health Care Card:	☐ No ☐ Yes Number:				
Financial Hardship:	☐ No ☐ Yes				
NDIS Registered:	☐ No ☐ Yes Number:				

Mental Health Presentations:			
Presenting Issues:			
Principal Diagnosis:			
Anxiety disorders:	☐ OCD	☐ Adjustment disorder	☐ Alcohol dependence
☐ Panic disorder	Depressive disorders:	☐ Oppositional defiant	☐ Drug dependence
☐ Agoraphobia	☐ Major depression	☐ Personality disorder	☐ Schizophrenia
☐ Social phobia	☐ Depressive symptoms	☐ Conduct disorder	☐ Other:_____
☐ Generalised anxiety	☐ Bipolar disorder	☐ Complex PTSD	
Severity: *(Please tick one)*	☐ Mild ☐ Moderate	☐ Severe Acute	☐ Severe Complex
Psychotropic Medication:	☐ None ☐ Hypnotics and sedatives ☐ Psychostimulants and nootropics	☐ Antidepressants ☐ Antipsychotics ☐ Anxiolytics	
Outcome Tool Score: *(Attach K10 form for the referral to be approved)*	☐ K10: ___ / 50	☐ Other:	
Previous Mental or Physical Health History or Treatment:			

Priority Group
☐ Child (0-12 years) ☐ Young adult (13-25 years) ☐ CALD ☐ Aboriginal and/or Torres Strait Islander ☐ Refugee/Asylum Seeker ☐ Severe and complex mental illness ☐ Perinatal ☐ LGBTIQ ☐ Elderly
Is this person currently at high risk of suicide? ☐ **Yes** ☐ **No**

Treatments:	
Referred for which Strategies:	☐ Psychological therapy ☐ Psychiatric services ☐ Suicide prevention service ☐ Other: _____
Preferred WentWest Provider:	Yes (Provider Name):
Preferred Modality:	☐ No preference (provider/service will be assigned by WentWest) ☐ Face-to-face ☐ Telehealth (Note: first preference may not be guaranteed)

Additional Information e.g. anger, self-harm, grief:

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 the patient understands and consents to the following:**

1. Understands that the information provided in this referral is required to determine eligibility for services with WentWest.
2. Gives consent for services to be provided by suitable programs, as requested on this referral.
3. Gives permission for the exchange of this information between Health Professionals and other agencies for the purpose of coordination of care.
4. Consents to de-identified information to be used for statistical purposes for WentWest and the Department of Health.

Signature: _____ **Date:** _____
(Include name for forms sent via HealthLink)

Please ensure the following is complete before sending it to WentWest:

- ✓ Medication List and Referral Letter for Psychiatry service
- ✓ Patient contact information including phone number
- ✓ Financial and priority group information including Medicare Card number
- ✓ Mental Health Treatment Plan and Outcome Assessment Tool is attached
- ✓ Consent section completed above

Send completed form and Mental Health Treatment Plan via:
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Primary Mental Health Care does not routinely accept referrals for the sole purpose of court reports and/or legal documentation.