Mental Health Referral Form

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

Patient Information:			
First name		**Last name**	
Address		**Suburb**	**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	
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	**Number:**	☐ No	
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	
☐ Social phobia	☐ Depressive symptoms	☐ Conduct disorder	☐ Schizophrenia
☐ Generalised anxiety	☐ Bipolar disorder	☐ Complex PTSD	☐ Other:_____
Severity	☐ Mild ☐ Moderate	Severe: ☐ Acute or ☐ Complex	
Psychotropic medication *(please tick all that apply)*	☐ None ☐ Hypnotics and sedatives ☐ Psychostimulants and nootropics	☐ Antidepressants ☐ Antipsychotics ☐ Anxiolytics	
Outcome tool score	☐ K10 (Please attach form)	☐ K5 ☐ SDQ	☐Other:_____
Previous mental or physical health history or treatment			

Priority Group

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

☐ Child (0-12 years) ☐ Young adult (13-25 years) ☐ CALD ☐ Aboriginal and/or Torres Strait Islander
☐ Refugee/Asylum Seeker ☐ Severe and complex mental illness ☐ Peri-natal ☐ LGBTIQ ☐ Elderly

Treatments

Referred for which stratergies	☐ Psychological therapy ☐ Psychiatric services ☐ Suicide prevention service ☐ Other:_____
Preferred WentWest Provider or Service	☐ No preference (Provider/service will be assigned by WentWest)

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

Referrer Details

Name		Profession	
Organisation type		Phone number	
Address		Fax number	
		HealthLink EDI	

Consent: Patient or parent/guardian for a child must be completed 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 Professional 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.

Referrer name: _____
(include name for forms sent via HealthLink)

Referrer signature: _____

Date: _____

Please ensure the following is complete before sending to WentWest:

- ✓ Patient contact information including phone number
- ✓ Financial and priority group information including Health Care Card number
- ✓ Mental Health Treatment Plan, outcome tool or medication list (psychiatric service is attached)
- ✓ Consent section above.

Send completed form and Mental Health Treatment Plan via:

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