Mental Health Services Helpline Referral

Phone: 1800 332 388

Fax: 03 6173 0306

PLEASE NOTE: Fax completed form to MHS Helpline (available all hours) 03 6173 0306 with any appropriate reports
Any confidential or urgent issues can be notified by telephone 1800 332 388.
Clear writing and current contact details are appreciated to avoid any delay in progressing this referral

Patient Details

Name _____ DOB _____

Address _____ Postcode _____

Phone _____ Mobile _____

Next of Kin/Carer _____ NOK/Carer Phone _____

Cultural Background _____ Preferred language *(If other than English)* _____

Indigenous or Torres Strait Islander? YES / NO Interpreter needed YES / NO

Referrer Details *(or stamp)*

Name _____

Address _____

Phone _____ Fax _____

Provider No. _____

Length of Referral ☐ indefinite ☐ other _____

Signature _____

PART A

1 Reason for Referral to Mental Health Services **☑ Tick all boxes that apply**

a ☐ Assessment and MHS to manage ☐ Assessment and co-management ☐ Medication advice and continued GP management ☐ Assessment and suggestions for GP to manage

☐ Other (please specify) _____

Additional Information: _____

b Urgency ☐ Routine ☐ Urgent *(please indicate what risk factors make this referral urgent)* _____

c Presenting Problem _____

d Mental Health System Review

Sleep	☐ Early Morning Wakening	☐ Poor Sleep	☐ No Sleep	Problem Duration _____
Appetite	☐ Significant weight loss	☐ Mild loss	☐ Excessive / unhealthy weight gain	
Energy and motivation	☐ Lack of energy	☐ Loss of motivation	☐ Mild anhedonia	☐ Marked anhedonia
Mood	☐ Abnormally low mood	☐ Elevated mood	☐ Irritability	☐ Abnormal mood changes
Delusions and hallucinations	☐ Delusional ideas	☐ Paranoia	☐ Hallucinations	☐ Command hallucinations

Other important factors _____

Mental Health History _____

Relevant Medical History _____

Social History _____

Current Medications _____

Issue date: 17 October 2017

2 Risk Factors ☑ Tick all boxes that apply

- ☐ Current suicidal thought / expressed intent
- ☐ Harm to others
- ☐ Alcohol and Drug use
- ☐ Care of children
- ☐ Family at risk
- ☐ Work at Risk
- ☐ Patient has plans / meant to attempt suicide
- ☐ Driving Risk
- ☐ Other – please specify below

Additional information _____

PART B – Children Under 18 Years *(please complete this section only when referring to children under 18 years)*

3 Consent

a Is this person able to consent as a mature minor? ☐ YES ☐ NO

b Please provide the details of a parent / guardian who give consent for the referral

Name: _____

Address: _____

Phone: _____ Postcode: _____

c Issues relevant to children

☐ Emotional ☐ Behavioural ☐ Family / Parental Issues ☐ Developmental ☐ Legal ☐ Physical

d Other services involved or considered *(please specify, e.g. paediatrician, allied health, child protection, school counsellors, courts)*

_____

_____

_____

PART C – Adults Aged 65 + *(please complete this section only when referring to adults aged 65 years and older)*

4 Older Persons

a Does this person live alone? ☐ YES ☐ NO

b Can they travel to an appointment? ☐ YES ☐ NO

c Who is the initial contact person? ☐ SELF ☐ Other _____

d Has this person been seen by ACAT or other services? ☐ YES ☐ NO ☐ UNSURE

e Details of ACAT or other services: _____

_____

f Does this person have involved family or service supports? ☐ YES ☐ NO

g Details of Family or Service Supports: _____

_____

h Does this person have their medication/s supervised? ☐ YES ☐ NO

i Does this person have a Webster pack? ☐ YES ☐ NO

j Is there a MMSE score available? ☐ YES ☐ NO Score: _____

PART D – *List Details of Attached Reports* _____

_____

_____

_____

_____

_____