

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		Referrer Details (or stamp)	
Name _____	DOB _____	Name _____	
Address _____	Postcode _____	Address _____	
Phone _____	Mobile _____	Phone _____	Fax _____
Next of Kin/Carer _____	NOK/Carer Phone _____	Provider No. _____	
Cultural Background _____	Preferred language _____ (If other than English)	Length of Referral _____	<input type="checkbox"/> indefinite <input type="checkbox"/> other
Indigenous or Torres Strait Islander? YES / NO	Interpreter needed YES / NO	Signature _____	

PART A

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

Other important factors _____

Mental Health History _____

Relevant Medical History _____

Social History _____

Current Medications _____

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

