PHN Mental Health Intake form

for Stepped Care services

PHN CENTRAL QUEENSLAND, WIDE BAY, SUNSHINE COAST

An Australian Government Initiative

This form is for:

- Self-referral
- Referrals from a family member or friend
- Referrals from allied health professionals
- Referrals from community organisations

For help completing the form or further information, please get in touch via contact details below.

Fax	Email	Website
1300 787 494	mentalhealthintake@ourphn.org.au	https://www.ourphn.org.au/mental-health/

Referrer Details

Referrer Name:

Date of referral:

Referrer organisation *(N/A for self or family referral)*:

Referrer profession OR relationship to client (e.g. social worker, self, carer etc.):

Referrer address:

Referrer phone:

Alternative phone (if applicable):

Referrer email address:

Client Information

Has the person given consent for referral to the PHN Mental Health Intake team for initial assessment? Yes No

If 'No', do not proceed with referral

Client name:

Date of birth: Age: Gender:

Country of birth: Preferred language: Interpreter required?

Address:

Suburb: Postcode**:**

Client phone:

Alternative phone (if applicable):

Email (if applicable):

Marital status:

Demographic Information

Tick if applicable, leave blank if unknown

Rural and Remote resident	Culturally and Linguistically Diverse background
Aboriginal and/or Torres Strait Islander	LGBTIQ communities member
Female with Perinatal depression	Financially disadvantaged (e.g. concession card holder)
Affected by Domestic Violence	Homeless (e.g. sleeping rough or couch surfing)
NDIS participant	Dept. Veterans Affairs card holder
Private health insurance	Currently employed

Risk Information

Tick 'Yes' or 'No' as applicable

Is the person currently experiencing suicidal thoughts?	Yes		No
Has there been a past suicide attempt?	Yes		No
If yes, was the attempt in the last 7 days?	Yes		No
Has the person recently self-harmed, or is there a history of self-harm?	Recent	History	No
Has the person been admitted to hospital for mental ill-health in the last 12 months?	Yes		No
Is there a risk of harm to others?	Yes		No

Referral Information

For more information on streams of care, see our website

Which level of support do you believe the person requires?

Please provide a brief reason for the referral:

Additional information

*Please type below or **attach** any additional information that you think is relevant (e.g. a K10+ assessment, mental health support plan)*

Send completed referrals via:

- **Fax:** 1300 787 494
- **Email:** mentalhealthintake@ourphn.org.au