|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | |  | | **PHN Mental Health Intake**  **Stepped Care services**  **For further information on Stepped Care services, see** [**HealthPathways**](file:///C:\Users\BP1\Documents\Best%20Practice\102577.htm)**.**  For any questions, please call PHN Mental Health Intake on 1300 747 724 or email on [mentalhealthintake@ourphn.org.au](mailto:mentalhealthintake@ourphn.org.au)  Send via Medical Objects:  MENTAL HEALTH CQ PHN  (PC4558000B1)  Alternatively fax to: 1300 787 494 | | | | | | | |
| **Referrer Details** | | | | | | | | | | | | | | | | | | |
| Referrer Name: | |  | | | | | | | | | | Date of Referral: | | | |  | | |
| Referrer Position/Profession: | |  | | | | | | | | | | Referrer Provider Number: | | | |  | | |
| Name of referring practice: | |  | | | | | | | | | | Referrer phone: | | | |  | | |
| Referrer Address: | |  | | | | | | | | | | | | | | | | |
| **Client Information** | | | | | | | | | | | | | | | | | | |
| **Has client given consent for referral?**  **Yes**  **No (if no – do not proceed)** | | | | | | | | | | | | | | | | | | |
| Client Name: | |  | | | | | | | | | | | | | | | | |
| DOB: | |  | | | Age: | | | | |  | | | | | | | Gender: |  |
| Ethnicity: | |  | | | Preferred Language: | | | | |  | | | | | | | Interpreter required: |  |
| Address: | |  | | | | | | | | | | | | | | | | |
| Suburb: | |  | | | | Postcode**:** | | | | |  | | | | | |
| Client Contact Details | **Mobile:** |  | | | | | | | | | | | | | | | | |
| **Home:** |  | | | | | | | | | | | | | | | | |
| **Work:** |  | | | | | | | | | | | | | | | | |
| **Email:** |  | | | | | | | | | | | | | | | | |
| Medicare No. | |  | | | | | | | | | | DVA number | | | |  | | |
| Health Care Card No. | |  | | | | | | | | | | Private Health No. | | | |  | | |
| Marital Status: | |  | | | | | | | | | | | | | | | | |
| Medication: | |  | | | | | | | | | | | | | | | | |
| Allergies: | |  | | | | | | | | | | | | | | | | |
| **Risk Information – if yes, provide details** | | | | | | | | | | | | | | | | | | |
| Current suicidal ideation? | | | |  | | Self- harm? | | | | | | | | |  | | | |
| Past suicide attempt? | | | |  | | Mental health hospital admission in the last 12 months? | | | | | | | | |  | | | |
| In the last 7 days? | | | |  | | Risk of harm to others? | | | | | | | | |  | | | |
| **Demographic Information** | | | | | | | | | | | | | | | | | | |
| Rural and Remote resident | | |  | | | | Culturally and Linguistically Diverse background | | | | | | |  | | | | |
| Aboriginal and/or Torres Strait Islander | | |  | | | | LGBTIQ community 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 | | |  | | | | DVA card holder | | | | | | |  | | | | |
| Private health insurance | | |  | | | | Has the patient seen a psychologist this calendar year under Better Access? | | | | | | |  | | | | |
| **Referral Information** | | | | | | | | | | | | | | | | | | |
| Which stream of support do you believe this person will be eligible for?   * Low intensity psychological support (e.g. 6 telephone psychology sessions) * Psychological therapy (e.g. 10 face-to-face psychology appointments) * Care coordination for severe and complex mental health conditions * Intensive care coordination following a suicide attempt * Aboriginal or Torres Strait Islander peoples-specific mental health support * Child and youth-specific mental health support | | | | | | | | | | | | | | | | | | |
| Reason for referral: | | | | | | | | | | | | | | | | | | |
| **Assessments** | | | | | | | | | | | | | | | | | | |
| Please indicate the score of any assessments undertaken:   * Kessler Psychological Distress Scale (K10+) * Kessler 5 Psychological Distress Scale (K5 - for Aboriginal and Torres Strait Islander people) * Short Form Survey (SF-12) * Health of the Nation Outcome Scale (HoNOS) * Patient Health Questionnaire (PHQ-9) * General Anxiety Disorder-7 (GAD-7) * Suicidal Ideation Attributes Scale (SIDAS) * Strengths and Difficulties Questionnaire (SDQ) | | | | | | | | | | | | | | | | | | |
| **GP Mental Health Treatment Plan** | | | | | | | | | | | | | | | | | | |
| Please attach patient's Mental Health Treatment Plan **(required for referral under Stream 3 – Psychological Therapies)** | | | | | | | | | | | | | | | | | | |