COMMUNITY-SERVICE PROVIDER'S REFERRAL FORM

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This referral form is to be completed by community-service providers (e.g. staff of mental-health services, general practitioner, psychologist, psychiatrist, case manager, etc). Please answer all questions where information is available.

Full and frank disclosure is appreciated when completing the form.

This will help us provide the best possible care for the participant.

(NOTE: We service clients from the following postcodes: 2600, 2601, 2602, 2603, 2604, 2609, 2612 and 2620)

1. **Date of referral:** ____________________

2. **Please provide the following information about the person making the referral (you).**

Name:	Organisation/Job title:
Telephone Number:	Fax Number:

3. **Please provide the following information about the person being referred (the participant):**

Name ______________________________ Date of birth ________________ Age _______

Address ____ Post code ______________

Telephone number/s____________________________

Gender:

☐ Male

☐ Female

Does the participant identify with these cultural backgrounds?

☐ Aboriginal or Torres Strait Islander

☐ Diverse Cultural and Linguistic Background

Country of birth______________________

4. **Please indicate if the participant uses of any of these ACT Mental Health Services.**

☐ City Mental Health

☐ Belconnen Mental Health

☐ Woden Mental Health

☐ Tuggeranong Mental Health

☐ MITT North

☐ MITT South

☐ Older Persons Mental Health

☐ Other____________________

5. **Please provide name and contact details of the participant's next-of-kin or carer.**

Name ________________________________ Phone ______________________

Their relationship to participant ____________________________________

6. **Why would the participant like to take part in the PHaMs Program? What kind of support is the participant seeking from PHaMs?**

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7. **Please provide name and contact details of all health professionals/services involved in the participant's care. (If there are any additional "Other's" please attach details separately)**

Clinical Manager ____________________________ Phone ____________________

Psychiatrist ____________________________ Phone ____________________

GP ______________________________________ Phone ____________________

Other ______________________________________ Phone ____________________

Other ______________________________________ Phone ____________________

8. **Does the participant have any diagnosis of a mental illness?**

☐ No

☐ Yes –Please list all current psychiatric diagnoses that have been diagnosed by a health professional. Include: who made the diagnosis; the date of the diagnosis (if available); and the type of treatment the participant is receiving (e.g. therapy, counselling, medication)

Diagnosis	Who made the Diagnosis	Date	Treatment type

9. **Has the participant been admitted to hospital in the last 2 years? (including psychiatric or acute care hospital, or correctional facility)**

☐ No ☐ Yes – Please provide details below

Admission date	Discharge date	Location (e.g. PSU)	Reason for admission

10. Does the participant use any drugs? (including alcohol, marijuana, heroin, ecstasy, etc; not including prescribed medications)

☐ No ☐ Yes – Please provide details below

Substance	How much and how often	How long used	Last used	Willing to address?

11. Does the participant have any disabilities, health problems or allergies?

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12. Does the participant have a current support-action plan or recovery plan with your service or another healthcare provider? (e.g. GP, psychologist, psychiatrist, social worker)

☐ No ☐ Yes – Please provide a copy attached with this referral

13. Does the participant experience any hallucinations or delusions?

☐ No ☐ Yes – Please give specific details including frequency, nature, current state and the consumer's reaction to these experiences.

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14. Is the participant known to engage in self-harm, or have suicidal ideation/attempts?

☐ No ☐ Yes – Please give specific details

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15. What is your assessment of the participant's current level of suicide risk?

☐ High Risk ☐ Low Risk ☐ High Variability

☐ Medium Risk ☐ Low confidence in assessment

16. What are the early warning signs that the participant is becoming unwell?

17. Does the participant have a history of violent or aggressive incidents?

☐ Unknown ☐ No ☐ Yes – Please give specific details

18. Where would be the participant's preferred venue for an Eligibility Screening Tool (EST) meeting?

☐ PHaMs office ☐ His/her residence ☐ Other locations – Please give specific details

19. Is there anything else you can tell us that you think will help us to provide the best possible support for the participant?

CONSENT TO RELEASE INFORMATION

Consent authorising the obtaining and / or release of personal information.

Mental Health Foundation employees will treat your information in a confidential manner however as we work in a team, all members of the team will have access to your information. If you are a client of other Mental Health Foundation ACT (MHF) services we will also share information with these services if this is in the interest of your care and treatment. We also have independent clinical supervision and may discuss aspects of your service provision with our supervisor in order to provide you with the best possible care and treatment. Information will be used to assist in identifying, planning and providing appropriate services to best meet your needs.

You have the right to request to review what information we are keeping on your personal record. You have a right to withdraw your consent for us to share your information.

I ______________________________________ hereby give my permission to any authorised officer of the MHF to release, or seek, confidential information from the following individuals or organisations in the interests of my care and treatment and in accordance with the ACT Health Records (Privacy and Access) Act 1997.

Individual or Organisation	Contact Person	Contact Details
Carer/ Emergency Contact		
ACT Mental Health Service		
General Practitioner		
Psychiatrist		
Psychologist		
Counsellor		
Other MHF Service		
Other		
Other		

Client Name	Signature	Date
Staff Witness name	**Signature**	**Date**