SELF-REFERRAL FORM

11/70 MacLaurin Crescent. Chifley, ACT 2606
Ph: (02) 6242 7195
Fax: (02) 6282 6674
phams@mhf.org.au

This referral form is to be completed by the person requesting support from PHaMs.

If you require any assistance completing this referral form, please contact us.

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.

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

1 Date of referral: _____

2 Please complete the following information about yourself:

Name _____ Date of birth _____ Age ____

Address _____ Post code _____

Telephone number(s) _____; _____

Gender:

☐ Male

☐ Female

Do you identify with these cultural backgrounds?

☐ Aboriginal or Torres Strait Islander

☐ Diverse Cultural and Linguistic Background

Country of birth _____

3 Please indicate if you are a consumer 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_____

4 Please provide name and contact details of your next of kin or carer.

Name _____ Phone _____

Their relationship to you _____

5 Why would you like to take part in the PHaMs Program? What kind of support are you seeking?

_____

_____

6 Please provide name and contact details of all your health professionals/services

Clinical Manager _____ Phone _____

Psychiatrist _____ Phone _____

GP _____ Phone _____

Other _____ Phone _____

7 Do you have any diagnosis of a mental illness?

☐ No

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

Diagnosis	Who made the Diagnosis	Date	Treatment type

8 Have you 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

9 Do you use any drugs? (including alcohol, marijuana, heroin, ecstasy, etc; <u>not</u> including prescribed medication)

☐ No ☐ Yes – Please provide details below

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

10 Do you have any disabilities, health problems or allergies?

_____

_____

_____

_____

_____

_____

_____

11 Do you have a current support action plan or recovery plan with another health care provider? (e.g. GP, psychologist, psychiatrist, social worker)

☐ No ☐ Yes – Please provide a copy attached with this referral or bring to the next appointment

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

_____

_____

_____

_____

_____

_____

_____

13 Where would be your preferred venue for an Eligibility Screening Tool (EST) meeting?

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

_____

_____

_____

14 Did someone help you complete this form (e.g. a family member, carer, support worker)?

☐ No ☐ Yes – Please write their details below.

Name _____ Signature _____

Relationship to you _____

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**