

Mental Health Service Referral Form

HEAD TO
HEALTH

CAREinMIND™

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NORTH WESTERN
MELBOURNE
An Australian Government Initiative

About NWMPHN mental health referral and access

1. The North Western Melbourne Primary Health Network (NWMPHN) mental health referral and access team is an entry point for eligible people seeking **primary mental health support in the NWMPHN region**.
2. Referrals are for people who are unable to access MBS subsidised or private mental health services.
3. Credentialled mental health clinicians will assess and allocate the referral to the most clinically appropriate service, and you will be informed of the outcome.
4. The client will be contacted directly by the service to schedule an appointment.
5. **For questions or referral support** – contact the mental health referral and access team on **(03) 9088 4277**.

Complete and fax this form to (03) 9348 0750 or send a password protected pdf to referralandaccess@nwmphn.org.au

How long will it take for my client to see a mental health professional? Clients generally have their first appointment with a mental health professional within 4 – 6 weeks of the PHN receiving the referral.

This is **NOT A CRISIS SERVICE**. If crisis support is required, please call **000** or your local emergency service.

Please note, services are restricted to people live work or study in the North Western Melbourne Primary Health area. [Find your local PHN](#)

PLEASE NOTE: * denotes mandatory information. If this information is not included, referral may be delayed or not accepted.

This form meets the minimum requirements for billing a Mental Health Treatment Plan (MHTP), therefore you are not required to attach a separate MHTP.

| | | |
|--|--|---|
| Referral Date*: | | |
| REFERRAL ELIGIBILITY * | | |
| If any of the below are ticked “yes”, the client is eligible to access free mental health services. | | |
| Is client experiencing severe financial hardship? | | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Reason for financial hardship: Provide short description of financial hardship: e.g. studying and no job or low or no income, disability support pension. | | |
| Does client hold a Health Care Card (HCC) or similar? | | <input type="checkbox"/> No <input type="checkbox"/> Yes Provide HCC number and expiry date: |
| Is the client from one the following priority population groups? (Please tick all that apply) | | |
| 1. Homeless or at risk of becoming homeless? | | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 2. Of Aboriginal and/or Torres Strait Islander origin? | | |
| 3. A child (under the age of 18)? | | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 4. Currently seeking asylum or has refugee status in Australia? | | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 5. Speaks a language other than English at home? | | <input type="checkbox"/> No Yes - (specify): If yes, is an interpreter required? <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 6. Is an international student? | | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 7. Identify as LGBTQ+? | | |
| If all of the above questions have been answered as “no”, consider contacting 1800 595 212 or referral to a private psychologist or psychiatrist where appropriate. | | |
| 8. Is client seeking a formal assessment for neurodevelopmental disorders or a report for matters relating to the justice system or mediation? | | <input type="checkbox"/> No <input type="checkbox"/> Yes – If yes, this referral is not eligible for NWMPHN mental health services. |
| CLIENT CONTACT INFORMATION* | | |
| Name*: Preferred Name: Last Name: | | Title: First Name: |

| | | |
|--|-----------------------------|--|
| DOB*: | Gender identity*: | |
| Country of Birth: | | |
| Phone*: | | |
| Address* (include postcode): | | |
| Email address: | | |
| Parent/Guardian name and phone number (if client is under age 16) * OR (for clients aged between 12 – 16 who are “mature minors”) <input type="checkbox"/> I have assessed the client as a “mature minor” and they understand the nature of the referral <input type="checkbox"/> I have spoken to client about informing parent or guardian about mental health referral and there is a clear reason why the parents have not been informed. If ticked, please reply reason: Click or tap here to enter text. | | |
| RISK ASSESSMENT* | | No Yes (If yes, provide details:) |
| 1. Is client currently at risk of harm from others? | | <input type="checkbox"/> Yes No |
| 2. Is client currently at risk of harm to others? (e.g. forensic history) | | <input type="checkbox"/> Yes No |
| 3. Is there evidence of self-harm? | | <input type="checkbox"/> Yes No |
| 4. Does client have suicidal thoughts? | | <input type="checkbox"/> Yes No |
| 5. Does client have suicidal intent? | | <input type="checkbox"/> Yes No |
| 6. Does client have a suicide plan? | | <input type="checkbox"/> Yes No |
| 7. Has client made a previous suicide attempt? | | <input type="checkbox"/> Yes If yes, include details and indicate how long ago. <input type="checkbox"/> Yes |
| Is the primary purpose of this referral to seek support to prevent suicide? | | <input type="checkbox"/> Yes No If yes, please fax to the suicide prevention intake on (03) 8080 8948. Clients with acute suicidality should be referred to Emergency Department or local Psychiatric Triage. |
| REASON FOR REFERRAL* | | |
| Provide a reason for referral including a mental state examination and relevant history (biological, psychological, social) affecting the person being referred. More detail here will help the NWMPHN mental health access team refer to the most appropriate support: | | |
| Sessions required: Up to 12 | | |
| CLIENT GOALS | | |
| Provide a description of the client's goals and related actions: | | |
| I have provided psychoeducation to the client <input type="checkbox"/> | | |
| ADDITIONAL INFORMATION | | |
| Does the client have a mental health diagnosis? | <input type="checkbox"/> No | <input type="checkbox"/> Yes If yes, provide details on the diagnosis: |
| Is the client prescribed medication for mental illness? | | <input type="checkbox"/> Yes If yes, provide details of medication and dosage: <input type="checkbox"/> No |
| Does client have other support services in place? | | <input type="checkbox"/> Yes If yes, provide details on the other services and their involvement. <input type="checkbox"/> No |

K10 Score:

IAR-DST Score: If you have completed at Initial Assessment and Referral Decision Support Tool, please add in the score here and/or attach the assessment with this form.

The IAR-DST can be completed at <https://iar-dst.online/#/>

| | |
|--|------------------|
| Other Measure: (e.g. DASS-21, SDQ): | (score) |
| REFERRER INFORMATION* | |
| Referrer Name*: | GP Name: |
| Referrer Profession*: | GP Organisation: |
| Referrer Organisation*: | Address: |
| Address*: | Postcode: |
| Postcode*: | Telephone: |
| Telephone*: | Fax: |
| Fax*: | Email: |
| Email*: | |

CLIENT CONSENT***1. Consent to receive service and for sharing of service delivery information ***

By signing this consent, you agree to **receive care** from the health provider who receives this referral and to share this information with that health provider.

- Yes, I (client) consent to share the information from our conversation today with health providers for the purposes of receiving care.***
- Yes, client has provided verbal consent.***
- No, I do not consent.***

2. Consent to share de-identified data with the Australian Government Department of Health and Aged Care (the Department), and independent evaluators *

To help improve this service, the Commonwealth, State and Territory Governments need to understand who is using it. They want to understand users' age, gender and location but not any personal details that can be linked back to you. Are you OK for us to share this information with the Department for evaluation of the service's use?

- Yes, I (client) consent to the sharing of some of my information with the funders of this service, the Department of Health, and independent evaluators engaged by them.***
- Yes, client has provided verbal consent.***
- No, I do not consent.***

3. Experience of service survey and evaluation of NWMPHN commissioned mental health services *

We would like to know about your experience of the mental health service you are referred to. A survey will be sent that you can choose to complete. Are you OK for us to use your email or mobile phone number to send you a link to the survey?

- Yes, I (client) consent to being contacted to participate in the evaluation of the service I receive. I agree that my contact details may be disclosed to the contracted evaluation provider for that purpose.***
- Yes, client has provided verbal consent.***
- No, I do not consent.***