



Mental Health Services Helpline Referral

Phone: 1800 332 388
Fax: 6236 5788

Please Note:

Fax completed form to MHS helpline (available all hours) 6236 5788 with any appropriate reports.

Any confidential or urgent issues can be notified by phone.

Clear writing and current contact details are appreciated to avoid delay in progressing this referral.

Patient Details		Date of Referral	Referrer Details (or stamp)		
Name	_____	DOB	_____	Name	_____
Address	_____	Postcode	_____	Address	_____
Phone	_____	Mobile	_____	Phone	_____ Fax _____
Next of Kin/Carer	_____	Next of Kin / Carer Phone	_____	Email	_____
Cultural Background	_____	Preferred Language (if other than English)	_____	Profession	_____
Indigenous or Torres Strait Islander?	YES / NO	Interpreter needed?	YES / NO	Signature	_____

PART A

I Reason for Referral to Mental Health Services Tick all boxes that apply

a Assessment and MHS to manage Assessment and co-management Medication advice and continued GP management Assessment and suggestions for GP to manage Other (specify below)

Additional Information _____

b **Urgency** Routine Urgent (Please indicate what risk factors make this referral urgent) _____

c **Presenting Problem**

d **Mental Health System Review**

Sleep	<input type="checkbox"/> Early Morning Wakening	<input type="checkbox"/> Poor Sleep	<input type="checkbox"/> No Sleep	Problem Duration _____
Appetite	<input type="checkbox"/> Significant / weight loss	<input type="checkbox"/> Mild Loss	<input type="checkbox"/> Excessive / unhealthy weight gain	
Energy and Motivation	<input type="checkbox"/> Lack of energy	<input type="checkbox"/> Loss of motivation	<input type="checkbox"/> Mild anhedonia	<input type="checkbox"/> Marked anhedonia
Mood	<input type="checkbox"/> Abnormally low mood	<input type="checkbox"/> Elevated mood	<input type="checkbox"/> Irritability	<input type="checkbox"/> Abnormal mood changes
Delusions and hallucinations	<input type="checkbox"/> Delusional ideas	<input type="checkbox"/> Paranoia	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Command hallucinations

Other important factors

Mental Health History

Relevant Medical History

Social History

Current Medications

2 Risk Factors Tick all boxes that apply

- | | |
|---|---|
| <input type="checkbox"/> Current suicidal thoughts / expressed intent | <input type="checkbox"/> Work at Risk |
| <input type="checkbox"/> Harm to others | <input type="checkbox"/> Patient has plans / means to attempt suicide |
| <input type="checkbox"/> Alcohol and Drug use | <input type="checkbox"/> Driving Risk |
| <input type="checkbox"/> Care of Children | <input type="checkbox"/> Other (specify below) |
| <input type="checkbox"/> Family at Risk | |

Additional information

PART B – Children Under 18 Years

Please complete this section only when referring children under 18 years

3 Consent**a** Is this person able to consent as a mature minor? YES NO**b** Please provide the details of a parent / guardian who gives consent for the referral

Name: _____

Address: _____

Phone: _____ Postcode: _____

c Issues relevant to children

-
- Emotional
-
- Behavioural
-
- Family / Parental issues
-
- Developmental
-
- Legal
-
- Physical

d Other Services involved or considered (please specify, e.g. paediatrician, allied health, child protection, school counsellors, courts)

PART C – Adults Aged 65 +

Please complete this section only when referring adults aged 65 and over

4 Older Persons**a** Does this person live alone? YES NO**b** Can they travel to an appointment? YES NO**c** Who is the initial contact person? SELF Other (please specify) _____**d** Has this person been seen by ACAT or other services? YES NO UNSURE**e** Details of ACAT or other services

f Does this person have involved family or service supports? YES NO**g** Details of Family or Service Supports

h Does this person have their medications supervised? YES NO**i** Does this person have a Webster pack? YES NO**j** Is there a MMSE score available? YES NO SCORE _____**PART D – List Details of Attached Reports**
