Mental Health Nurse Program Referral Form

Please fax to 02 9673 6856 (*Mandatory Fields)

Wentworth Healthcare

Blue Mountains | Hawkesbury | Lithgow | Penrith

Referring Doctor*		Phone No.*	
Address*		Date of Referral*	

Patient Name*		Gender	☐ M ☐ F
Address *		Date of Birth*	
Mobile Phone *		Home/work phone	

Eligibility Criteria (The patient must meet all of the criteria to be eligible for Mental Health Nurse)

Criteria 1*	**Criteria 2***	**Criteria 3***	**Criteria 4***
Primary Diagnosis/Presenting Complaint: (please tick all that apply) ☐ Depression ☐ Bipolar disorder ☐ Psychosis / schizophrenia ☐ Adjustment disorder ☐ Generalised anxiety ☐ Panic disorder ☐ Phobic disorder ☐ Obsessive Compulsive Disorder ☐ PTSD ☐ Drug and alcohol misuse ☐ Personality disorder ☐ Behavioural disturbance ☐ Other:	☐ The disorder causes significant disablement to the patient's social personal and occupational functioning	☐ the patient is expected to require continuing treatment and management of their mental health disorder over the next two years	☐ The patient has experienced at least one episode of hospitalization for treatment of mental health disorder, or is at risk of requiring hospitalisation in the future if appropriate treatment and care is not provided

Criteria 5* ☐ A **Mental Health Treatment Plan** has been developed **and is attached** to this referral form

Additional Information to support the Consumer

Does the person speak a language other than English at home? ☐ No ☐ Yes	Is an interpreter required? ☐ No ☐ Yes	Does the person live on his/her own? ☐ No ☐ Yes	Has the person ever received specialist mental health care before? (public/private, medical, allied health) ☐ No ☐ Yes ☐ Unknown	Receiving Psychotropic Medication (please tick all that apply) ☐ None ☐ Benzodiazepines ☐ Anti-Depressants ☐ Antipsychotics ☐ Mood Stabilisers ☐ Other – please list
If yes, what language is spoken?				

Is there a history of aggression towards health professionals? (*For safety assessment purposes only. Will not affect acceptance of referral*) ☐ No ☐ Yes ☐ Verbal aggression ☐ Physical aggression

Reason For Referral

What would you like us to do? What issues need to be addressed? (Attach a separate sheet if insufficient space

As the patient's general practitioner / psychiatrist I am principally responsible for the patient's clinical mental health care.

Practitioner Signature: _____Date: _____

Patient consent: I give consent for information about my mental health and wellbeing to be collected, used and disclosed between my GP and mental health provider to whom I am referred, where this is required to assist in the management of my health care; and; I am aware that my name and date of birth will be collected and securely stored by the Nepean Blue Mountains PHN, for the purpose of accurately tracking referrals; and I am also aware that information (that will not identify me to any external parties) is being collected and used to assist in improving the regional MHNIP program. I understand de-identified information pertaining to services accessed will be recorded in the secure Primary Mental Health Care, Minimum Data Set (Australian Government, Department of Health) and that information handling and storage will be in adherence to the *Australian Government Privacy Act, 1988.*

Patient Signature: _____Date: _____

phn NEPEAN BLUE MOUNTAINS

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