

SOS SERVICE
Nepean Blue Mountains PHN
Referral Patient Detail Form



Blue Mountains | Hawkesbury | Lithgow | Penrith

SOS REFERRAL CODE:		DATE OF REFERRAL:	
PATIENT DETAILS			
Name:		Phone:	
Address:			
KEY SUPPORTS			
Name:		Name:	
Phone:		Phone:	
Relationship to patient:		Relationship to patient:	
<i>Patient has given consent for GP/Provider to contact support people: YES / NO</i>			
Living status: Living alone: <input type="checkbox"/> Living with family <input type="checkbox"/> Living with carer / friend <input type="checkbox"/>			
REASON FOR REFERRAL			
KEY RISKS IDENTIFIED / RECENT STRESSORS			
DIAGNOSIS (if applicable) / MENTAL HEALTH HISTORY		MENTAL HEALTH PLAN COMPLETED: YES / NO	
CURRENT MEDICATIONS / CURRENT HEALTH CONDITIONS			
OTHER MENTAL HEALTH PROFESSIONALS CURRENTLY INVOLVED (e.g. psychiatrist, MH Team, Social Worker)			
Name:		Contact Details:	
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 <u>not</u> identify me to any external parties) is being collected and used to assist in improving the regional Psychological Therapy Services (PTS) 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 <i>Australian Government Privacy Act, 1988</i> .			
Signature:		Date:	

NB: This form is to be sent to the SOS Provider

