Telepsychiatry Referral Form

This referral is only valid with a unique referral code obtained from the Wentworth Healthcare intake line.
To obtain a referral code, GPs and other approved referrers must contact the Intake team on 1800 223 365.

UNIQUE REFERRAL CODE:		**DATE OF REFERRAL:**
GP DETAILS		
Name:		Practice name:
Practice phone:		HealthLink EDI:
PATIENT DETAILS		
Name:		DOB:
Healthcare card number:		Expiry date:
Medicare number:	Ref #	Expiry date:
Known mental health diagnosis (Primary):		
Known mental health diagnosis (Secondary):		
Medications:		
Has the patient experienced a recent history of self-harm, suicide attempt or were thoughts of suicide or self-harm a factor in obtaining this referral ■ Yes ☐ No		
Labour force participation: ☐ Employed ☐ Unemployed/looking for work ☐ Not in the labour force		
Patient income: ☐ <16 years old ☐ Paid employment ☐ Disability Support ☐ Other pension ☐ Nil		
Relationship status: ☐ Married or De facto ☐ Never Married ☐ Widowed ☐ Divorced ☐ Separated		
KEY SUPPORTS: Patient has given consent to contact support person: ☐ Yes ■ No		
Name:		Phone:
Relationship to patient:		
OTHER MENTAL HEALTH PROFESSIONALS CURRENTLY INVOLVED IN PATIENT'S CARE		
Name:		Phone:
Name:		Phone:
Patient has given consent to contact ☐ Yes ☐ No		
REASON FOR REFERRAL		
ADDITIONAL REFERRAL NOTES		

Patient Consent: By consenting to this referral, I understand that all information in this referral, and any previous referrals (where applicable) including my personal information, will be collected for the primary purpose of delivering care; and for the ongoing monitoring, reporting, evaluation, and improvement of services. I consent with the understanding that this information will only be used, disclosed, and stored for its primary purpose, between my health service provider(s), the Department of Health, and the Nepean Blue Mountains Primary Health Network (NBMPHN) and affiliated partner organisation(s)*, in accordance with the *Australian Government Privacy Act, 1988.*

** Affiliated partner organisation(s) means those required to support the monitoring, reporting, evaluation and/or clinical governance for the service.*

Patient Signature: **Date:**

Consent for children and young people

Parent/Guardian/Carer Name:

Contact number: **Email:**

Signature: **Date:**

☐ **Patient, or guardian has given informed verbal consent on (date):**

GP STAMP OR SIGNATURE AND DATE
PLEASE ENSURE THE FOLLOWING STEPS ARE FOLLOWED BEFORE SENDING TO DOKOTELA
☐ This referral form is complete & includes a referral code obtained from Wentworth Healthcare ☐ A current K-10 or K-5 (suitable for Aboriginal and Torres Strait Islander peoples, or, for children and adolescents between 8-17, an age-appropriate version of the SDQ has been completed and is attached ☐ There is a current mental heath treatment plan attached ☐ A medication summary and patient psychiatric history has been attached

Please send completed referral form and attachments to DOKOTELA Pty Ltd
HealthLink EDI: Dokotela
Secure Fax: (02) 8569 1844