SOS SERVICE
Nepean Blue Mountains PHN
Referral Patient Detail Form

SOS REFERRAL CODE:	**DATE OF REFERRAL:**
AHP Name:	**AHP Fax Number:**
PATIENT DETAILS	
Name:	**Phone:**
Address:	**DOB:**
GP DETAILS	
Name:	**Practice Phone Number:**
Practice Address:	**Practice Fax Number:**
KEY SUPPORTS	
Name:	**Phone:**
Relationship to patient:	
Patient has given consent for GP/Provider to contact support people: YES / NO	
Living status: Living alone: ☐ Living with family ☐ Living with carer / friend ☐	
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 not 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 *Australian Government Privacy Act, 1988.*	
Signature:	Date:

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