Please send completed referral via Medical Objects Secure electronic transfer: LP4030000BW.

\*\*\*Please complete all referral details for referral to be processed efficiently and do not hand write in form \*\*\*

If acute mental health and/or risk of harm identified, call Mental Health Acute Care Team 1300 642 255 or ‘000’.

|  |  |
| --- | --- |
| Which program are you referring to? | Choose an item. |
| Preferred location for service |       |
| Date: |       |
| Referrer Details |
| Referrer Name: | TEST | Practice Name: |       |
| Practice Postcode: |       | GP Provider Number: |       |
| Practice Email: |       | Referrer Phone Number: |       |
| Client Details Re: |
| Name: |       | DOB: | 01/01/2020 |
| Phone: |       | Email: |       |
| Suburb: |        | Concession Card: | Choose an item. |
| Gender: | Choose an item. | LGBTIQ: | Choose an item. |
| Indigenous Status: | Choose an item. | Culturally and/or Linguistically Diverse: | Choose an item. |
| Country of Birth: |       | Preferred Language: |       |
| Proficiency in Spoken English: | Choose an item. | Interpreter Required: | Choose an item. |
| Consent: By consenting to this referral, the person is consenting to the sharing of their personal information. This information is held in a referral system repository by the Brisbane North PHN. The information contained in the referral is used by Brisbane North PHN to: (1) deliver care, (2) for monitoring, aggregate reporting and evaluation purposes to improve quality and access to care. Personal information is never shared or reported by any staff at Brisbane North PHN. This information will be passed on to the referral organisation who will contact the person unless requested otherwise.Choose an item. |
| Guardian/carer/parent Details |
| Name: |       | Phone: |       |
| Email: |       | Relationship to Client: |       |
| Emergency contact details |
| Name: |       | Phone: |       |
| Relationship to Client: |       |
| Referral Details |
| Reason for Referral – Please indicate if there are any concerns around safety, domestic violence of problematic alcohol or drug use that the referral organisation should consider before phoning the person or visiting their home address (in certain programs)                                                                                          |
| Recent transition to Parenthood? | Choose an item. | Are present symptoms related to a history of trauma? | Choose an item. |
| Detail the impact symptoms are having on daily functioning: |       |
| Assessment Areas: Brisbane North PHN utilises the Initial Assessment and Referral Guidance from the Department of Health to support referrers in determining the best level of care for a person. For more information, a copy of the [full guidance is available here](https://d1jydvs1x4rbvt.cloudfront.net/downloads/Mental-health-services/National-MH-IAR-Guidance-17Dec2019_V1.03-Accessible.pdf?mtime=20200707192013&focal=none)  |
| Symptom severity and distress: | Choose an item. | Diagnosis: |       |
| Risk of harm: | Choose an item. | Risk to others: | Choose an item. |
| Suicidal Ideation: | Choose an item. | Psychosis: | Choose an item. |
| Self-Injury: | Choose an item. | Risk comments |       |
| Functioning: | Choose an item. | Impact of co-existing conditions: | Choose an item. |
| Treatment and Recovery History: | No prior treatment history | Social and environmental Stressors: | Choose an item. |
| Family and other supports: | Choose an item. | Engagement and motivation: | Choose an item. |
| Mental Health Treatment Plan: | Choose an item. |  |
| Further notes/information about Primary Assessment Domains:      |