PHN mental health intake form

for stepped care services

phn CENTRAL QUEENSLAND, WIDE BAY, SUNSHINE COAST
An Australian Government Initiative

This form is for:

- Hospital and health staff
- Allied health professionals
- Clinicians within community organisations

To send **completed referral form,** or for help completing the form, please contact the PHN Intake Team via:

Phone	Fax **(preferred)**	Email **(see below)**
1300 747 724	1300 787 494	mentalhealthintake@ourphn.org.au

Client privacy is our concern. Please keep in mind that communications via email are not secure. Although it is unlikely, there is a possibility that information included in an email can be intercepted and read by other parties. By emailing us, you agree that the client consents and accepts this risk.

IMPORTANT REFERRAL INFORMATION

Fields with * denote a mandatory field. Referral will NOT be accepted if field is left blank.

Stepped Care Intake is NOT an acute service. Clients with significant risk should be referred to the local Acute Care Team by calling 1300 MH CALL (1300 642 255).

Referrer Details

Referrer name*		Date of referral*	
Referrer position/profession*		Referrer phone*	
Referrer email		Referrer fax	
Referrer address*			

Client Consent and Basic Client Demographics

Has consent been given for referral?* ☐ Client consent ☐ Guardian consent ☐ No (do not proceed)

If under 18, but mature minor, can referral be discussed with guardian?* ☐ Yes ☐ No ☐ N/A (>18)

Is it OK for the PHN to contact the client/guardian, if required? ☐ Call ☐ SMS ☐ Do not contact

Client name*					
DOB*			Gender*		
Indigenous identity (tick relevant)*	Torres Strait Islander ☐		Aboriginal ☐		
Country of birth*		Preferred Language		Interpreter required	
Co-morbidities / medical history (if known)					
Substance use (if applicable)					

Client GP Details (if known)

GP name		GP phone number	
GP clinic name		GP fax	

Other Client Demographics

NB – these fields are required to determine eligibility for psychological therapies

GP MH Treatment Plan*	☐ Completed	☐ Not completed	☐ Unknown
Homelessness*	☐ Sleeping rough	☐ Emergency accommodation	☐ Not homeless
Employment	☐ Unemployed	☐ Employed part-time	☐ Employed full-time
Financial disadvantage*	☐ No	☐ Yes - if yes, provide concession card no.	
Source of income*	☐ Paid employment	☐ Disability Support Pension	☐ Other
	☐ Nil income	☐ Other Pension (eg NewStart)	☐ Unknown
NDIS and support coordination*	☐ NDIS with support coordination	☐ NDIS without support coordination	☐ No NDIS
Rural or remote (MM4-7)* (See search tool to check)	☐ Rural or remote	☐ Not rural or remote	☐ Unknown
CALD*	☐ Yes CALD	☐ No CALD	☐ Unknown
LGBTIQ+*	☐ Yes LGBTIQ+	☐ No LGBTIQ+	☐ Unknown
Perinatal depression	☐ Yes	☐ No	☐ Unknown
Domestic/family violence	☐ Affected by DFV	☐ Perpetrator DMV	☐ No DMV
Private health insurance	☐ Yes	☐ No	☐ Unknown

Client Contact Details

Address				
	Suburb*		Postcode	
Client mobile*			Client home phone	
Guardian name and contact (if applicable)				

Referral Information

What support do you believe this person requires?*

☐	Low intensity mental health support (e.g. 6 telephone coaching sessions)
☐	Psychological therapy (e.g. 6 face-to-face psychology appointments)
☐	Care coordination for severe and complex mental health conditions
☐	Intensive coordination following a suicide attempt – The Way Back Support Service **(referrals from hospital only)**
☐	Aboriginal or Torres Strait Islander peoples-specific mental health support

Reason for referral*

Risk Information

The below section is based on the Initial Assessment and Referral national guidance.

It is a **provisional assessment only** and aims to inform the most appropriate response and/or referral.

Suicidality*

- ☐ 0 = No risk
- ☐ 1 = Low risk (e.g., no current suicidal ideation but may have experienced ideation in the past)
- ☐ 2 = Moderate risk (e.g., current suicidal ideation, without plan or intent)
- ☐ 3 = High risk (e.g., current suicidal ideation with intent; history of attempts; some protective factors)
- ☐ 4 = Extreme risk (e.g., current suicidal intention with plan and means to carry out)

Self-harm (non-suicidal self-injurious behaviour)*

- ☐ 0 = No risk
- ☐ 1 = Low risk (e.g., occasional self-harming behaviours in recent past, not requiring surgical treatment)
- ☐ 2 = Moderate risk (e.g., frequent self-harming behaviours in recent past, not requiring surgical treatment)
- ☐ 3 = High risk (e.g., frequent self-harming behaviours in recent past requiring surgical treatment)
- ☐ 4 = Extreme risk (e.g., long history of repeated, life-threatening self-harm or dangerous behaviour)

Risk of harm to self and others*

- ☐ 0 = No risk
- ☐ 1 = Low risk (e.g., past behaviours that posed a risk to others)
- ☐ 2 = Moderate risk (e.g., recent behaviours that pose non-life-threatening risk to self or other)
- ☐ 3 = High risk (e.g., recent life-threatening risk to self or others)
- ☐ 4 = Extreme risk (e.g., recent behaviour that poses an imminent danger to self or others)

If moderate risk or greater in any category, please add comments*

Has a safety plan been completed?

☐ Yes – if yes, attach if possible ☐ No

Has the client ever been hospitalised due to their mental health?

☐ Yes – if yes, date of most recent admission: ☐ No

Assessments

Please indicate the score of any assessments undertaken

	Kessler Psychological Distress Scale (K10+)
	Kessler 5 Psychological Distress Scale (K5 - for Aboriginal and Torres Strait Islander people)
	Suicidal Ideation Attributes Scale (SIDAS)
	Depression, Anxiety and Stress Scale (DASS-21)
	Other – please specify

GP Mental Health Treatment Plan (MHTP)

Where possible, please attach GP MHTP. A plan is required for a referral for **psychological therapies (Stream 3)** and **adult clinical care coordination (Stream 4).** It is recommended for **child and youth care coordination (Stream 2).**

If MHTP does not accompany referral, the PHN will accept a 'provisional' referral, providing that a MHTP is obtained by the client in a reasonable time after the first session.