Adelaide Primary Mental Health Care Services (PMHCS)

Item 2715/2717/2701/2700

Please note these details MUST be provided before the Mental Health Treatment Plan will be accepted by the PMHCS Central Referral Team for allocation to a service provider: Patient details, GP Details, Problem, diagnosis, Risk Assessment, Patient Consent and GP signature

Step 1: Patient Assessment

Patient Details *(must complete)*

Name:		**Outcome Tool Results: K10/DASS (please circle)**	
Address:		**Phone Number:**	
DOB:		**Gender:**	
Referral Date:		**Medicare No#**	
Does the patient identify as Aboriginal or Torres Strait Islander?			☐ Yes ☐ No
Is the patient from a Culturally and Linguistically Diverse background?			☐ Yes ☐ No
Does the patient have a My Health Record?			☐ Yes ☐ No

Patient Demographics

Has the patient ever received specialist mental health care? ☐ Yes ☐ No **Language spoken at home:** ☐ English ☐ Italian ☐ Greek ☐ Cantonese ☐ Mandarin ☐ Arabic ☐ Vietnamese ☐ Other please specify_____
How well does the patient speak English: ☐ Very Well ☐ Well ☐ Not Well ☐ Not at All
Does the patient require an interpreter? ☐ Yes ☐ No
Does the patient live alone: ☐ Yes ☐ No If no, with whom_____ **Is the accommodation:** ☐ Stable ☐ Unstable
Country of birth:_____ **Nationality:**_____
Employment Status: ☐ Student ☐ Unemployed ☐ Employed full time ☐ Employed part time ☐ Home Duties ☐ Other
Pension or Health Card Status: ☐ Aged ☐ Disability ☐ Repatriation ☐ Unemployment Benefit ☐ Sickness Benefit ☐ Other
Marital Status: ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Defacto ☐ Widowed
Does the patient have any dependents: ☐ Yes ☐ No if yes, please tick ☐ Spouse ☐ Children ☐ Other

Psychosocial assessment: (e.g. childhood, substance abuse, relationship history, coping with previous stressors)	
Eligibility Criteria for Primary Mental Health Care Services (please tick all that is applicable) ☐ low income ☐ Homeless ☐ CALD ☐ Aboriginal or Torres Strait Islander ☐ LGBTQI ☐ Socially Isolated ☐ New and emerging populations ☐ Perinatal ☐ Comorbid presentation ☐ Risk of suicide and self-harm ☐ Underserviced group ☐ Unable to access Better Access.	
Mental Status Examination:	
Appearance and General Behaviour ☐Normal ☐Other:	**Mood** (Depressed/Labile) ☐Normal ☐Other:
Thinking (Content/Rate/Disturbances) ☐ Normal ☐ Other:	**Affect** (Flat/Blunted) ☐Normal ☐Other:
Perception (Hallucinations etc.) ☐Normal ☐Other:	**Sleep** (initial Insomnia/Early Morning Wakening) ☐Normal ☐Other:
Cognition (level of Consciousness/Delirium/Intelligence) ☐Normal ☐Other:	**Appetite** (Disturbed Eating Patterns) ☐Normal ☐Other:
Attention/Concentration ☐Normal ☐Other:	**Motivation/Energy** ☐Normal ☐Other:
Memory (Short and Long Term) ☐Normal ☐Other:	**Judgement** (ability to make rational decisions) ☐Normal ☐Other:
Insight ☐Normal ☐Other:	**Anxiety Symptoms** (Physical & Emotional) ☐Normal ☐Other:
Orientation (Time/Place/Person) ☐Normal ☐Other:	**Speech** (Volume/Rate/Content) ☐Normal ☐Other:
Other Mental Health Professionals involved in patient care	
Name/Profession:	Contact number:

GP Details

Name:		**Practice Name:**	
Address:		**Phone:**	

Presenting Problem/ Provisional diagnosis *(must complete)*

Number 1	**Number 2**	**Number 3**

Risk Assessment *(must complete)*

Suicidal ideation:	☐ Yes	☐ No	**Suicide intent**	☐ Yes	☐ No
Current suicidal plan:	☐ Yes	☐ No	**Risk to others**	☐ Yes	☐ No

GUIDE TO ABOVE RISK ASSESMENT OUTCOME:

If **YES** to one or more of the above Risk Assessment questions please contact your local service provider.

If **NO** to the above Risk Assessment Clinical Triage will determine the service provider based on information supplied in this referral.

Other Comments

Medications:	**Allergies:**
Relevant physical and mental examination:	

Patient history

Include relevant biological, psychological and social history including any family history of mental disorders and any relevant substance abuse or physical health problems.

Step 2: Mental Health Care Plan

Key family contact/support details/phone:		
Emergency Care/relapse prevention:		
Initial action plan:		
GOAL	**TREATMENT**	**REFERRALS**
Review date: (Add a recall in clinical software for 4 months after the **Plan** date)		
Copy of Mental Health Treatment Plan given to Patient:		

Patient Consent to release information (must complete)

I, _____ (patient name-please print clearly) understand that this MHTP is being used as a referral for the provision of mental health services. This process involves an assessment and the development of a plan for treatment. I agree to be part of the process with the knowledge that:

- My medical history will be shared with the GP and Clinician of the service chosen/and personnel of the chosen service where relevant;
- The information collected is private and will be kept confidential unless agreed upon by all parties to be shared;
- My GP has explained to me the reasons for seeking counselling/therapeutic input;
- No Medico Legal Reports will be provided;
- I understand that my treatment will be monitored and communicated between my treatment team.
- All personal information gathered will remain confidential and secure with my treating team and within the clinical management system hosted by the funding body APHN

Therefore, in complying with the principles governing provision of this service we seek your consent.

Patient signature_____ **Date**:_____

GP Signature_____ **Date**:_____

For patients under 16 years:
Carer name:_____ **Carer signature**_____

PLEASE FAX YOUR COMPLETED REFERRAL FORM TO THE PMHCS CENTRAL REFERRAL TEAM ON: 1300 580 249