MHNP Referral Form

To be completed by referrer. Complete all sections of this form and return this form to referrals@richmondtas.com.au. For more information, please contact 03 6228 3344.

Has the Participant given consent to share their information with us? ☐ Yes ☐ No

Participant Name: _____ **Date of birth:** _____

Email: _____ **Phone:** _____

Address: _____

Gender: ☐ Male ☐ Female ☐ Other: _____ **Preferred Pronouns:** _____

Identifies as LGBTQIA+: ☐ Yes ☐ No

Cultural background: _____

Preferred language: _____

Requires interpreter: ☐ Yes ☐ No

Aboriginal or Torres Strait Islander Origin:

☐ Yes, Aboriginal ☐ No

☐ Yes, Torres Strait Islander

Mental health diagnosis: _____

Diagnosed by: _____

Eligibility

☐ **GP Treatment Plan (mandatory, if GP referral)** **Date of Plan:** _____

☐ **Or Psychiatrist referral (include last assessment notes)**

☐ Require long term management of the mental health disorder.

☐ Mental health illness significantly impacts participant's social, personal, an/or occupational function.

☐ A diagnosed mental health illness

☐ Primary GP / psychiatrist maintains responsibility for participant management.

☐ Has been previously hospitalised for treatment of mental health illness, or at risk of hospitalisation.

Notes:

Tick all that applicable

☐ Appetite / food intake ☐ Sleep problem ☐ Hallucinations

☐ Elevated mood ☐ Depressed mood ☐ Delusions

Tick all that applicable

☐ Substance misuse ☐ Other. Please specify: _____

Are you prescribed medication to use in an emergency? ☐ Yes. Please specify: _____

☐ No

Notes:

Risk Assessment *(required)*

☐ No known risks ☐ Risk of self-harm / injury

☐ Risky behaviours that put themselves/others in danger ☐ At risk of abuse by others (physical / sexual / emotional / financial)

☐ History of verbal/physical aggression ☐ Other: _____

☐ Suicidal thoughts / ideation ***(if you tick this, please complete with participant)***

1. **In the past month**, have you wished you were dead or wished you could go to sleep and not wake up? ☐ Yes ☐ No
2. **In the past month,** have you had any thoughts about killing yourself? ☐ Yes ☐ No
   (if you tick YES, please answer below)
   - Have you been thinking about how you might do this? ☐ Yes ☐ No
   - Have you had some intention of acting on these thoughts? ☐ Yes ☐ No
   - Have you started to work out on the details of how to kill yourself? Did you intend to carry out this plan? ☐ Yes ☐ No
3. **In your lifetime,** have you done anything, started to do anything, or prepared to do anything to end your life? ☐ Yes ☐ No
4. **In the past 3 months**, have you done anything, started to do anything, or prepared to do anything to end your life? ☐ Yes ☐ No

The risk rating is ☐ Low ☐ Medium ☐ High

We are not a crisis service and is unable to support participants who are actively suicidal. Acceptance of this referral will be based on participant's suicide risk assessment at the initial meeting.

Carer / Emergency Contact Details

Name:		**Relationship:**	
Email:		**Phone:**	

Other Stakeholders

If applicable, please provide details of participant's stakeholders.

Role / organisation	Name	Contact details
☐ Adult Mental Health		
☐ Forensic Mental Health		
☐		
☐		

Referrer Details

Name: _____

Address: _____

Email: _____ **Phone:** _____

Signature: _____ **Date:** _____