GP REFERRAL FORM
Brisbane South PHN Mental Health Referral Service

The Brisbane South PHN Mental Health Referral Service provides information and support to GPs to streamline the referral process into PHN-commissioned mental health services. The information provided in this form will be used to determine an appropriate service pathway. Following initial determination by the Referral Service, the referral will then be sent to the relevant commissioned mental health service for further assessment of program eligibility. For more information or support contact the Referral Service by phone on 07 3151 3841.

Date of referral: _____

Personal information

Full name: _____
Preferred name:_____
Date of birth: _____
Gender: ☐Male ☐Female
☐ Other - please specify: _____
Pronouns: ☐He/Him/His ☐ She/Her/Hers ☐They/Them/Theirs
Phone number: _____
OK to leave message ☐ Yes ☐ No
If not client's phone - name and relationship:

_____

Email: _____
Street Address: _____
Suburb: _____**Postcode**: _____
Note: The person is ineligible to access Brisbane South PHN-commissioned services if residing outside of the region.
Country of Birth: ☐Australia ☐Other: _____
Main Language Spoken at Home:
☐English ☐Other_____
Proficiency in English:☐N/A (<5 years/speak only English)
☐Very well ☐Well ☐Not well ☐Not at all
☐Interpreter Required - language: _____

Does the person identify with any of the following?
*Please indicate **all** that apply:*

☐ Aboriginal
☐ Torres Strait Islander
☐ Both Aboriginal and Torres Strait Islander
☐ Culturally and linguistically diverse
☐ Lesbian, gay, bisexual, transgender, intersex, queer
☐ Refugee background / asylum seeker
☐ Child (0-11 years) with, or at risk of, developing a mental illness or behavioural/emotional disorder
☐ Living in a rural or remote community (MMM2+)

Is the person experiencing any of the following?

☐ At risk of suicide or self-harm
☐ Perinatal depression/anxiety (Child<2)
☐ Domestic and family violence
☐ Financial disadvantage or hardship
☐ At risk of, or experiencing, homelessness
☐ Sleeping rough / non-conventional
☐ Short-term or emergency ☐ At risk homelessness

Marital Status: ☐Divorced ☐Married (registered/de facto)
☐ Separated ☐Widowed ☐Never married
Own Primary Source of Income: ☐ Nil income
☐ Full Time Paid Employment ☐ Part Time Employment
☐ Disability Support Pension ☐ Other pension/benefit
☐ Other (e.g. superannuation) ☐ Compensation payments

Carer / support person details

Full name: _____
Relationship to person: _____
Phone number: _____
Email: _____

Referrer details

Referrer name: _____
Role: _____
Practice name: _____
Suburb: _____
Postcode: _____
Phone number: _____
Email: _____
Fax: _____

Clinical information

Reasons for referring and/or principal diagnosis:

Treatment goals and strategies:

Results of assessment tools administered:
☐ K10 Result: _____
☐ K5 Result: _____
☐ SDQ Result: _____
☐ Other:_____Result: _____

Brisbane South PHN has commissioned Wesley Mission Queensland to operate the Brisbane South PHN Mental Health Referral Service. Any personal information is collected, used and disclosed by Wesley Mission Queensland in accordance with our Privacy Policy available at www.wmq.org.au/privacy-policy

Risk assessment (noting any identified risks, including harm to self or others, potential hospitalisation, psychosis, problematic substance use):

In the past 4 weeks, has the client had thoughts about hurting themselves or ending their life:

☐ Yes ☐ No

PHN-commissioned mental health services are not a crisis response. If the person is at imminent risk of harming themselves or others, contact 000.

For urgent mental health advice, the person or yourself can contact 1300 MH CALL on 1300 642 255.

For advice on alcohol and other drug treatment referral, the person or yourself can contact Alcohol and Drug Information Service (ADIS)1800 177 833.

Has a GP Mental Health Treatment Plan been completed?

☐ Yes - *please attach a copy to this referral*

☐ No

Please detail services currently accessing, previous service history or any additional comments:

Relevant medical history (e.g. medications, comorbidities, hospitalisations, family history):

Has the client been hospitalised for Mental Health concern in last 12 months: ☐Yes ☐No

Service referral recommendations

Please indicate which PHN-commissioned service/s you wish to refer the person to. If unsure, tick ***Not Known*** and the Referral Service will determine an appropriate service to refer to based on the information provided. The service will then contact the individual to complete an assessment and confirm eligibility into their program.
For service specific eligibility criteria visit *SpotOnHealth HealthPathways* or contact the Referral Service on 07 3151 3841.

Would the person prefer to access a dedicated organisation that supports people who identify as:

☐ **Aboriginal and Torres Strait Islander** ☐ **Culturally and Linguistically Diverse** ☐ **LGBTIQ+**

Please choose **one** of the below options:

☐ **Low intensity/ early intervention**: short term mental health services for people with, or at risk of, a mental health condition. Includes groups, self-guided help, education, and peer support.

☐ **Mild-to-moderate:** psychological therapies for people in under-serviced and/or hard to reach populations. Mental health clinician provides **short-term** psychological intervention for people unable to access services under the Medicare-funded Better Access Initiative. Essential criteria includes **experiencing financial disadvantage or hardship.**

☐ **Severe and complex:** clinical care coordination for people experiencing mental ill-health that is significantly impacting their social, emotional, personal and work-life, provided by a mental health clinician.

☐ **Severe and complex (Non-clinical):** psychosocial support for people experiencing mental ill-health that is significantly impacting their social, emotional, personal and work-life, which includes services designed to improve social skills, manage daily living needs and support independence.

☐ **headspace:** mental health services for young people aged 12-25 years with or at risk of, a mental health condition. ☐ **Capalaba** ☐ **Inala** ☐ **Meadowbrook** ☐ **Woolloongabba**

☐ **Social and Emotional Wellbeing** for Aboriginal and Torres Strait Islander peoples and their families.

☐ **Not Known:** Referral Service to determine appropriate pathway based on information provided.

Consent

You confirm that the person has been informed about and consented to:

☐ information on this referral form being shared with Wesley Mission Queensland (operator of the Referral Service) and other PHN-commissioned services relating to the person's service options

☐ the person's carer/support person identified on this referral form being contacted by the referred service

☐ information on this referral form being shared with the Brisbane South PHN for statistical purposes

☐ de-identified information on this referral form being shared with the Department of Health for statistical purposes.

Referrals can be submitted to the Brisbane South PHN Mental Health Referral Service via:
Secure message - Medical Objects: Brisbane South PHN Mental Health Referral Service WMQ (GW4106000JX)
Fax: 07 3539 6444