

Referral Inquiry Form for Low Intensity

Feeling Better Program

1. Advice to referrer

Our Low Intensity Service in the Brisbane South area is aimed at improving the wellbeing of those clients aged 16 years and over who have mild mental health issues.

If eligible, clients will be entitled free of charge to undertake the Feeling Better program, consisting of a 1 hour face-to-face initial session, followed by 6x30 minute sessions either by phone or face-to-face. Under the guidance of a mental health professional they will learn skills and strategies using evidence-based cognitive-behavioural therapy.

2. Eligibility

To be eligible for Low Intensity sessions, clients need to meet the following criteria:

1. Aged 16 years plus
2. Result on K10+ of 24 or less (administered by Artius triage officer)
3. Low risk across all domains
 - Low complexity
 - Stable presentation
4. Have a presentation that is suitable for brief therapy (1hr initial session followed by 6 x 30 minute sessions).

Clients who score higher than 24 on the K10+ (i.e. those in the “Moderate” and “Severe” categories) can be accepted into Low Intensity if:

- They are considered able to benefit from a Low Intensity program
- They have a stable presentation
- Their presenting problem is suitable for treatment through brief therapy (1hr initial session followed by 6 x 30 minute sessions).

3. How to refer

To refer someone to the program please complete the following and obtain consent from client (either verbal or written) for exchange of information – see next page:

DETAILS OF PERSON BEING REFERRED	
Name of person to be referred	
Date of Birth	
Best Telephone Contact	
Does this person identify as being of Culturally and Linguistically Diverse (CALD) background (having been born in a country other than Australia)?	Circle one: Yes No
Does this person identify as being of Aboriginal or Torres Strait Islander (ATSI) background?	Circle one: Yes No



DETAILS OF PERSON REFERRING CLIENT	
Name of person referring client	
Organisation	
Contact Number of person referring client	
Email of person referring client	

4. Client consent

Written Consent (if possible)

I (the client) authorise the referrer to exchange and obtain information with Artius Health:

Client name: _____

Client signature: _____ Date: _____

OR

Verbal Consent (if written consent not possible)

I have obtained the verbal consent of the client to exchange and obtain information with Artius Health:

Referring person's name: _____

Referring person's signature: _____ Date: _____

5. What to do next

Email this referral to Artius Health at: health@artius.com.au

Alternatively: Fax (07) 5502 7414

For inquiries: Phone 1300 986 886