COMMUNITY MENTAL HEALTH CLINICAL CARE AND COORDINATION REFERRAL FORM

ELIGIBILITY CRITERIA:

- The person is aged between 18 – 65 years old has been diagnosed with a mental illness according to the criteria defined in the World Health Organization Diagnostic and Management Guidelines for Mental Health Disorders in Primary Care: ICD 10 Chapter V Primary Care Version, or the Diagnostic and Statistical Manual of Mental Health Disorders - Fifth Edition (DSM-5)
- The person's mental health is significantly impacting their social, personal and work life
- The person is at risk of being admitted to hospital in the future if clinical care coordination is not provided, or they have already had at least one admission due to their mental health in the past 12 months
- The person is assessed as needing clinical care coordination for their ongoing treatment and management of their mental health for an extended episode of care
- The person is currently working with a GP or Psychiatrist on their clinical mental health care, or will be linked with a GP or Psychiatrist as part of the program
- The person has a Mental Health Care Plan, or have one developed as part of program

1. REFERRER (INDIVIDUAL COMPLETING THIS DOCUMENT)

Contact Name:

Position/Relationship:

Organisation (if applicable):

Postal Address:

Post Code: Phone: Mobile: Fax:

Email:

2. CLIENT DETAILS

First Name: Surname:

☐ Male ☐ Female ☐ Intersex
☐ Other ☐ Trans ☐ Non-binary

Date of Birth: Gender: ☐ Not Stated

Address:

Suburb: Postcode: State:

Home Phone: Mobile:

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Please provide as much information as possible as it ensures the best quality of care and outcomes for the individual. If the person is experiencing high levels of distress which may result in harm to themselves or others, please refer them directly to your local Emergency Department for immediate assistance as the Community Mental Health Clinical Care and Coordination Team is not a Crisis Service or equipped to manage these types of emergencies.

3. Reason For Referral:

4. Information About The Client

(If Applicable) Risk to self or others (Include self-harm/ suicide attempts, violence, threats of violence)

Date	Type of Behavior	Reason for Behavior	Outcome/ Treatment Provided

(If Applicable) Other Agencies / health care providers currently involved within the individual's care: (e.g. Government, non Government, GP's, Psychiatrists, and Community Services)

Name of Organisation	Contact Person	Address	Phone

5. Presenting Issues

☐ Anxiety	☐ Pain management issues	☐ Pending legal matters	☐ Suicidal
☐ Major depression	☐ Financial difficulty	☐ Difficulty sleeping	☐ Depression
☐ Physical abuse	☐ Loss of appetite	☐ Eating problems	☐ Self harm
☐ Relationship issues	☐ Physical disability	☐ Drug abuse	☐ History of hospitalisation
☐ Harm or threats to others	☐ Sexual abuse	☐ Crying	☐ Intellectually impairment
☐ Hallucinations and delusions	☐ PTSD / Trauma history	☐ Body image	☐ Emotional abuse
☐ Bullying others	☐ Domestic violence	☐ Psychotic disorder	☐ Presentation to ED or Hospital
☐ Past or present contact with Child Safety		☐ Other _____	

6. Does the Person identify as:

☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander
☐ Neither Aboriginal or Torres Strait Islander ☐ Not stated
☐ Culturally or linguistically diverse ☐ Country of birth _____
☐ Perinatal

Do you have any final comments or relevant information?

_____

_____

_____

7. CONSENT OF CLIENT REFERRED

I am aware that this referral is being made. I understand that I can withdraw from this referral or from the referred service at any time.

Please NOTE: Referrals will not be processed without signed consent.

I give permission for **The Benevolent Society** to use my contact details above for future contact with me. ☐ Yes ☐ No

I give permission for the **staff** at The Benevolent Society to obtain relevant information from government and non-government agencies, GP's and other health professionals specifically relevant to my care whilst being a client of their services. ☐ Yes ☐ No

I give permission for **The Benevolent Society** to share de-identified data to the Department of Health for statistical purposes ☐ Yes ☐ No

Signed: _____Print Name: _____Date: _____

8. WHAT NEXT?

On receipt of a referral form **the client** will be contacted by the service provider to advise of outcome and then if applicable contact to the client to arrange an appointment.

Please forward completed referral form to The Benevolent Society's Intake Team:

Email: MHIntake@benevolent.org.au

Fax: 07 3299 3713

Alternatively, please contact the office on 07 3441 3010 for more information

Other useful information Our privacy policy contains information about how you may access and correct your personal information, as well as how to complain about a breach of the Australian Privacy Principles and how we will deal with such a complaint. It also contains other useful information. Our privacy policy is available on our website at www.benevolent.org.au or email us at privacy@benevolent.org.au for a copy. Please feel free to direct queries on our privacy practices to our Privacy Officer at:

M - PO Box 171, Paddington NSW 2021

T - 02 8262 3400

E - privacy@benevolent.org.au

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