

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
 Not Stated

Date of Birth: _____

Gender: _____

Address: _____

Suburb: _____

Postcode: _____

State: _____

Home Phone: _____

Mobile: _____

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

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

6. DOES THE PERSON IDENTIFY AS:

This program is supported by funding from Brisbane South PHN

- 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