PROVISIONAL REFERRAL FOR: LGBTIQ

Psychological Support Services (PSS)

This form is required to refer people who identify as part of the LGBTIQ community who are experiencing mild to moderate mental health concerns and for whom available services (including Medicare subsidised services) are not suitable, for assessment and short term psychological intervention.

THIS IS NOT A CRISIS SERVICE, if crisis assistance is required, please call the Mental Health Access Line on **1800 011 511**

Eligible Provisional Referrers Include: Managers in NGO's.

Please Note: This referral is for two (2) FREE provisional sessions only; a combined GP Initial PSS referral and Mental Health Treatment Plan is required to approve further sessions.

SUBMIT COMPLETED REFERRALS via SECURE FAX: (02) 9330 9988 or HEALTHLINK ID: CESPHNMH

DATE OF REFERRAL	/ /

Program Eligibility *(please check each item - patient must meet each criteria below to be referred)*

- ☐ Client lives, works or goes to school in the Central and Eastern Sydney region
- ☐ Client has NOT accessed Medicare rebated psychological services this calendar year under Better Access
- ☐ Client is unable to access other available services, including Better Access
- ☐ Client is experiencing mild to moderate mental illness
- ☐ Client would benefit from short term psychological intervention
- ☐ Client is not better suited to a crisis or specialist domestic violence services and is not involved in court or insurance matters
- ☐ Client identifies as part of the LGBTIQ community

REFERRER DETAILS

Name		Position	
Organisation Name		Postcode	
Phone		Fax	
E-mail			

**** please note that if an e-mail address is not provided you will not receive referral confirmation.*

CLIENT DETAILS

First Name		Last Name	
Date of Birth			
Marital Status	☐ Never Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Married/De facto		
Current Gender Identity	☐ Male ☐ Female ☐ Non-binary ☐ Different Identity		
Address			
Suburb		Postcode	
Phone 1		Phone 2	
Healthcare Card	☐ Yes ☐ No	NDIS Participation	☐ Yes ☐ No
Aboriginal and/or Torres Strait Islander	☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Unknown		
Country of Birth		Cultural Identity	
Main language spoken at home			
Proficiency in spoken English	☐ Very well ☐ Well ☐ Not Well ☐ Not at all		

For referral information or support please contact CESPHN Mental Health Intake on: Phone (02) 9330 9999

MENTAL HEALTH SELF-ASSESSMENT TOOL (to be completed by patients over 16 years old)

K10+ *(please note, this is an updated version of the K10 - questions 11-14 are excluded from total score)*							
In the last 4 weeks:		**None of the time**	**A little of the time**	**Some of the time**	**Most of the time**	**All of the time**	**Not stated / Missing**
1	about how often did you feel tired out for no good reason?	☐	☐	☐	☐	☐	☐
2	about how often did you feel nervous?	☐	☐	☐	☐	☐	☐
3	about how often did you feel so nervous that nothing could calm you down?	☐	☐	☐	☐	☐	☐
4	about how often did you feel hopeless?	☐	☐	☐	☐	☐	☐
5	about how often did you feel restless or fidgety?	☐	☐	☐	☐	☐	☐
6	about how often did you feel so restless you could not sit still?	☐	☐	☐	☐	☐	☐
7	about how often did you feel depressed?	☐	☐	☐	☐	☐	☐
8	about how often did you feel that everything was an effort?	☐	☐	☐	☐	☐	☐
9	about how often did you feel so sad that nothing could cheer you up?	☐	☐	☐	☐	☐	☐
10	about how often did you feel worthless?	☐	☐	☐	☐	☐	☐
					TOTAL SCORE		
11	how many days were you totally unable to work, study or manage your day to day activities because of these feelings?	(Number of Days)					
12	aside from those days, in the past four weeks, how many days were you able to work or study or manage your day to day activities, but had to cut down on what you did because of these feelings?	(Number of Days)					
13	how many times have you seen a doctor or any other health professional about these feelings?	(Number of Consultations)					
14	how often have physical health problems been the main cause of these feelings?	☐	☐	☐	☐	☐	☐

CO-MORBID ISSUES	
Please indicate if the client has any of the below co-morbid issues	
☐ Chronic physical illness	☐ Personality issues
☐ Drug and alcohol issues	☐ Psychosocial stressors
☐ Intellectual disability	☐ Suicidality
☐ Psychiatric co-morbidity	

DESCRIPTION OF PRESENTING COMPLAINT(S)/PROBLEM(S): Please provide as much information as possible (e.g. psychological/emotional/behavioural/physical/social problems)
N.B. Please attach additional information or copies of assessments if available.

RISK ASSESSMENT: If risk is high please refer to the Mental Health Access Line on: **1800 011 511**

Suicidal thoughts	☐Yes ☐No	Suicidal intent	☐Yes ☐No
Current plan	☐Yes ☐No	Recent attempt	☐Yes ☐No
Recent self-harm	☐Yes ☐No	Risk of harm from others	☐Yes ☐No

CLIENT PREFERRED PSS PROVIDER NAME (Subject to availability and may be left blank):
Directory available at https://www.cesphn.org.au/PSS

1.	
2.	

NEXT OF KIN

Name		Phone	
Relationship		Permission for CESPHN and/or Mental Health Professional to contact	☐ Yes ☐No

CLIENT CONSENT: *Referral cannot proceed without client consent*

☐ Referrer confirms that the client understands and consents to the following;

- The above Provisional Referral to be sent to CESPHN and understands that a GP Mental Health Treatment Plan is required to approve further sessions
- That CESPHN collects and shares information within the requirements of the Privacy Act 1988, with the PSS Provider Organisation and treating Mental Health Professional
- That their de-identified data will be used for reporting and evaluation purposes
- That they will be contacted by the allocated PSS Provider Organisation or Mental Health Professional to arrange an appointment
- That they may be contacted by CESPHN or its representative to complete a client experince of care survey ☐ Yes ☐ No

REFERRER SIGNATURE:		**DATE:**	/ /