REFERRAL FORM

Primary Integrated Care Supports Program (PICS) Program

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

SUBMIT COMPLETED REFERRALS via SECURE FAX: (02) 1300 112 489 or HEALTHLINK ID: CESPHNMH

DATE OF REFERRAL	/ /

Program Eligibility: To be eligible to access the proposed services, clients need to (please tick):

- ☐ Be aged between 18 and 65 years
- ☐ Live, work or study in the Central and Eastern Sydney PHN region
- ☐ Can benefit from accessing primary care mental health services
- ☐ Not currently be care coordinated by Mental Health Services through the Local Health District services; and
- ☐ Referrer ensures that there is no duplication of services if client is accessing an NDIS package.

In addition, clients must meet <u>THREE</u> of the FOUR following criteria (please tick):

- ☐ Have a diagnosed mental illness which is severe and either episodic or persistent in nature (according to the criteria defined in the World Health Organisation 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 mental illness significantly impacts at least two areas of the client's social, personal and/or occupational functioning
- ☐ The mental illness has resulted in hospital treatment in the previous two years or there is a risk of hospitalisation within the next 12 months if clinical care by a mental health nurse is not provided
- ☐ The client is expected to need ongoing treatment and management of their mental illness proceedings

REFERRER DETAILS (GPs, psychiatrists, state mental health services, non-government organisations, mental health nurses and peer workers)			
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	
Marital Status	◯ Never Married ◯ Widowed	◯ Divorced ◯ Separated	◯ Married/De Facto
Date of Birth	/ /	Gender	◯ 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		

DESCRIPTION OF PRESENTING COMPLAINT(S)/PROBLEM(S): Please provide as much information as possible (e.g. psychological/emotional/behavioural/physical/social problems)

Please attach additional information/documents if available. Please note these documents will be uploaded onto WTCC.

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
Self-Harm	◯ Yes ◯ No	Risk of harm from others	◯ Yes ◯ No

CLIENT PREFERRED PICS PROVIDER NAME (Subject to availability and may be left blank):

1.	
2.	

NEXT OF KIN / CARER (if applicable)		**EMERGENCY CONTACT (if different from next of kin)**	
Name		Name	
Relationship		Relationship	
Phone		Phone	

CLIENT CONSENT: *Referral cannot proceed without client consent*

Referrer confirms that the client consents to the following:

- Client agrees to receive treatment from a mental health nurse.
- Client agrees to support from a peer worker.
  Please tick ◯ Yes ◯ No
- Client agrees to discuss the usefulness of a peer worker with One Door Mental Health.
  Please tick ◯ Yes ◯ No
- Client understands that they (or their next of kin) will be contacted by the mental health nurse or peer worker to arrange their first appointment.
- Client agrees to their clinical and non-clinical information being shared with One Door Mental Health and mental health nurse.
- Client agrees to their clinical and non-clinical information, including this referral form being shared with CESPHN for administrative and project evaluation purposes.
- Client agrees to their health information such as date of birth, gender and types of services used, to be shared with the Department of Health for mandatory reporting requirements.
  Please tick ◯ Yes ◯ No

CLIENT SIGNATURE		**DATE:**	/ /
REFERRER SIGNATURE:		**DATE:**	/ /