phn SOUTH WESTERN SYDNEY
An Australian Government Initiative

SWSPHN MENTAL HEALTH CENTRAL INTAKE

Enquiries: 1300 797 746 (1300 SWSPHN) **Referrals: Confidential fax line 4623 1796**

GP REFERRAL FORM

Referrals cannot be accepted without the patient's signed consent – see reverse
PLEASE PRINT CLEARLY

Date:	GP Name:	Practice Name:
GP Phone:	GP Fax:	Practice Suburb:
GP Email:		

Patient Details

Title:	First Name:	Last Name:

Address:	Suburb:	Postcode:
Phone: Home	DOB:	Sex
Phone: Mobile	Ethnicity:	
Marital Status:		

Country of Birth:	Language spoken at home:
Proficiency in Spoken English:	Medicare Number / Individual Reference Number (IRN):
Health Care Card:	NDIS participant:
Source of income:	Housing Status:

Emergency Contact:

Name:	Relationship:	Phone:

Thank you for agreeing to see____, who is currently a patient of mine.

1) I have assessed their needs and have completed the following Pre-treatment Outcome measure:

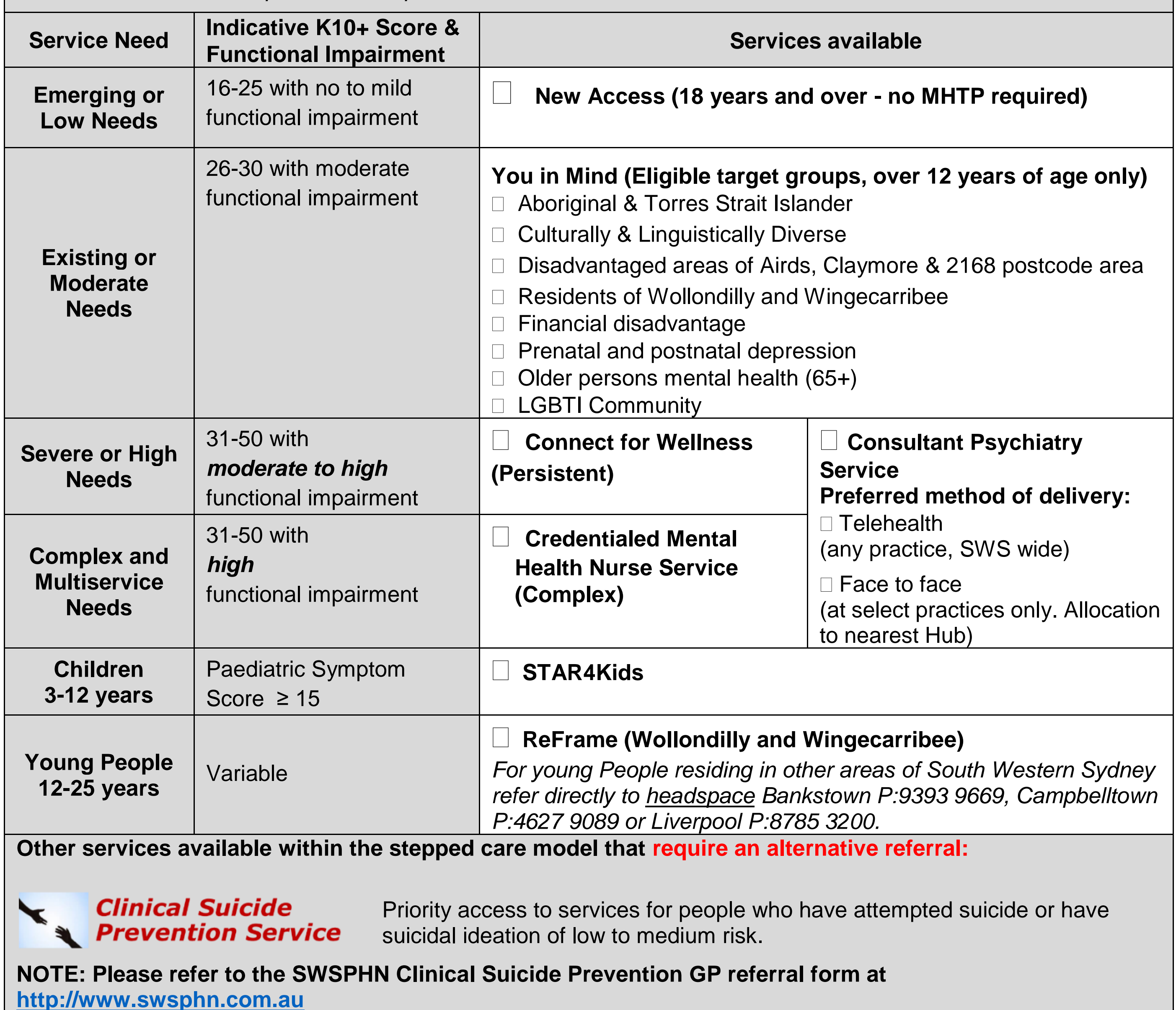
Tool	Score
K10+ (people over 12 years)	
K5 (Aboriginals and Torres Strait Islanders only)	
Paediatric Symptom Check (Children only)	

2) Prepared an initial Mental Health / Child Treatment Plan
3) I have gained consent for this referral from the patient (parent/guardian if child referral)
4) I have indicated the service that best fits the current needs of my patient on the reverse.

☐ I request ____ as the treating mental health professional for my patient and understand that this MHTP may not have the availability for a timely response (Please refer to website for current list of mental health professionals at http://www.swsphn.com.au).

OR

☐ I request that my patient be allocated to the most appropriate mental health service/professional by SWSPHN.



STEPPED CARE *please tick required service*

Service Need	Indicative K10+ Score & Functional Impairment	Services available	
Emerging or Low Needs	16-25 with no to mild functional impairment	☐ **New Access (18 years and over - no MHTP required)**	
Existing or Moderate Needs	26-30 with moderate functional impairment	**You in Mind (Eligible target groups, over 12 years of age only)** ☐ Aboriginal & Torres Strait Islander ☐ Culturally & Linguistically Diverse ☐ Disadvantaged areas of Airds, Claymore & 2168 postcode area ☐ Residents of Wollondilly and Wingecarribee ☐ Financial disadvantage ☐ Prenatal and postnatal depression ☐ Older persons mental health (65+) ☐ LGBTI Community	
Severe or High Needs	31-50 with ***moderate to high*** functional impairment	☐ **Connect for Wellness (Persistent)**	☐ **Consultant Psychiatry Service** **Preferred method of delivery:** ☐ Telehealth (any practice, SWS wide) ☐ Face to face (at select practices only. Allocation to nearest Hub)
Complex and Multiservice Needs	31-50 with ***high*** functional impairment	☐ **Credentialed Mental Health Nurse Service (Complex)**	
Children 3-12 years	Paediatric Symptom Score ≥ 15	☐ **STAR4Kids**	
Young People 12-25 years	Variable	☐ **ReFrame (Wollondilly and Wingecarribee)** *For young People residing in other areas of South Western Sydney refer directly to headspace Bankstown P:9393 9669, Campbelltown P:4627 9089 or Liverpool P:8785 3200.*	

Other services available within the stepped care model that require an alternative referral:

Clinical Suicide Prevention Service — Priority access to services for people who have attempted suicide or have suicidal ideation of low to medium risk.

NOTE: Please refer to the SWSPHN Clinical Suicide Prevention GP referral form at http://www.swsphn.com.au

I,____ (**patient, parent or guardian name)**

(please print clearly)

Consent to this referral and I agree to information about my mental health being recorded in my medical file and shared between the GP, South Western Sydney PHN Central Intake to assist in the management of my health care and the Mental Health Professional to whom I am referred.

I understand that SWSPHN will provide information that does not identify me, such as the types of I service I receive, to the Department of Health to assist improvement of mental health services in Australia.

☐ I do not consent to sharing of information with the Department of Health

____ ____________________

Signature (patient, parent or guardian): **Date**

I (GP) have undertaken an assessment and prepared a Mental Health Treatment Plan / Child Treatment Plan for my patient. I have discussed the proposed referral with my patient and am satisfied that the patient understands the proposed uses and disclosures and has provided their informed consent to these.

__________________________ __________________________ ______________

Signature (GP): **GP Name** **Date**

Please FAX completed Referral Form and a copy of the GP Mental Health Treatment Plan to
SWSPHN Central Intake on confidential fax line 4623 1796
Our Mental Health Central Intake clinicians are happy to answer your questions regarding referral and treatment planning on
1300 797 746 (1300 SWS PHN)