

Goldfields Integrated Primary Mental Health Care Program

Referral Form for:

GP, Psychiatrist, Eligible Nurse Practitioner within a collaborative arrangement,
 Medical officer in a non-government organisation,
 School Psychologist/ Counsellor or Senior Staff (Deputy Principal or higher)



Tel: (08) 9080 0379 Fax: (08) 6444 7459

Email: enquiries@goldfieldsmentalhealthportal.com.au

The Integrated Primary Mental Health Care () services are for clients experiencing mild to moderate mental health issues or experiencing severe and complex symptoms requiring care coordination. Patients at immediate risk of self harm or suicide should be referred directly to a Hospital Emergency Department.

Should clients be uncontactable for up to seven (7) calendar days from the date of referral, the clinical risk of the client shall in no way transfer to the Mental Health Portal Services.

Referrer Details	
GP / Referrer Name:	
Practice / Organisation Name:	
Role / Title:	
Date:	

Patient Contact Details	
Name:	
Address:	
Phone Number/s:	
Date of Birth:	Country of Birth:
Indigenous Status:	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both Aboriginal and Torres Strait Islander <input type="checkbox"/> Neither Aboriginal or Torres Strait Islander
If Patient is under 18 parent/guardian signature is required:	

Is the patient aware of this referral?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is it ok to leave a phone message for patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient signature as consent of referral:	

GP 'Principal' Diagnosis	
<input type="checkbox"/> Attention deficit hyperactivity disorder (ADHD)	<input type="checkbox"/> Cyclothymic disorder
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Acute stress Symptoms
<input type="checkbox"/> Depression	<input type="checkbox"/> Major Clinical Depression
<input type="checkbox"/> Obsessive-compulsive disorder	<input type="checkbox"/> Symptoms of Post-traumatic stress disorder
<input type="checkbox"/> Symptoms of Bipolar disorder	
GP 'Principal' Diagnosis Continued	
<input type="checkbox"/> Brief psychotic disorder	<input type="checkbox"/> Eating disorder
<input type="checkbox"/> Agoraphobia	<input type="checkbox"/> Panic disorder
<input type="checkbox"/> Somatoform disorder	<input type="checkbox"/> Other
<input type="checkbox"/> Symptoms of Personality disorder	

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Is there a Mental Health Treatment/Care Plan attached?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the patient at Suicide Risk?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Medication Prescribed:

Antipsychotics Anxiolytics Hypnotics Antidepressants Psychostimulants

Principal Focus of Treatment (*Must tick at least one of the following*)

LIPI: Low Intensity Psychological Intervention

PsychT: Psychological Therapies

Clinical Care Coordination: Nurse led coordinated support for severe and complex presentations

This service requires a K10 (*NOT a DASS*) - GP to complete

K10 Completed – Patient Signature: _____

K10 In the past 4 weeks:		None of the time	A little of the time	Some of the Time	Most of the time	All of the time
1	About how often did you feel tired out for no good reason?	1	2	3	4	5
2	About how often did you feel nervous?	1	2	3	4	5
3	About how often did you feel so nervous that nothing could calm you down?	1	2	3	4	5
4	About how often did you feel hopeless?	1	2	3	4	5
5	About how often did you feel restless or fidgety?	1	2	3	4	5
6	About how often did you feel so restless you could not sit still?	1	2	3	4	5
7	About how often did you feel depressed	1	2	3	4	5
8	About how often did you feel that everything was an effort?	1	2	3	4	5
9	About how often did you feel so sad that nothing could cheer you up?	1	2	3	4	5
10	About how often did you feel worthless?	1	2	3	4	5
Total out of 50						