

Suicide Prevention Service GP Referral Form – September 2019

Complete this form and fax to (03) 8080 8948

Date of Referral:		REASON FOR REFERRAL: <i>See descriptor over the page</i>	
REFERRER DETAILS: Referrer Relationship to client: Referrer Name: Referrer Organisation: Address: Postcode: Telephone: Fax: Email:		<input type="checkbox"/> Suicide Prevention Support Service NOTE: Clients with more acute suicidality should be referred to Emergency Dept or CATT.	
CLIENT/PATIENT DETAILS:			
Name: Title: First Name: Last Name: Preferred Name:			
DOB: Marital Status: Country of Birth:			
Phone: (M)		Parent/Guardian name: (if child under age 16)	
Address: (include postcode):			
Email address:			
Preferred contact method to organise first treatment session:		<input type="checkbox"/> Phone/mobile <input type="checkbox"/> Email <input type="checkbox"/> Phone/mobile <input type="checkbox"/> Email	
Preferred contact method for evaluation purposes:		<input type="checkbox"/> Phone/mobile <input type="checkbox"/> Email <input type="checkbox"/> Phone/mobile <input type="checkbox"/> Email	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other Does client identify as LGBTIQ: <input type="checkbox"/> Yes <input type="checkbox"/> No Does client identify as: <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both Aboriginal and Torres Strait Islander <input type="checkbox"/> Non Indigenous		Language spoken at home: <input type="checkbox"/> English only <input type="checkbox"/> Other If other, specify: _____ English Level: <input type="checkbox"/> Very well <input type="checkbox"/> Well <input type="checkbox"/> Not Well <input type="checkbox"/> Not at all Interpreter required: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify language required: _____	
Does client hold a Health Care Card or similar? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please write HCC Number and expiry date: _____			
Is client a National Disability Support Scheme (NDIS) participant? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has client been homeless in the previous 4 weeks? <input type="checkbox"/> Sleeping rough <input type="checkbox"/> Short term/emergency accomm <input type="checkbox"/> Not homeless		Employment participation: <input type="checkbox"/> Full Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Not in the labour force	
		Is client at risk of suicide? Thoughts <input type="checkbox"/> Yes <input type="checkbox"/> No Intent <input type="checkbox"/> Yes <input type="checkbox"/> No Plan <input type="checkbox"/> Yes <input type="checkbox"/> No Previous attempt <input type="checkbox"/> Yes <input type="checkbox"/> No	
Principal Diagnosis (using DSM-IV) – Please tick all that apply (if known) <i>NOTE: A mental health diagnosis does not need to be indicated.</i> <input type="checkbox"/> Anxiety Disorders <input type="checkbox"/> Mood Disorders <input type="checkbox"/> Substance use disorders <input type="checkbox"/> Psychotic disorder <input type="checkbox"/> Disorders with onset usually occurring in childhood and adolescence <input type="checkbox"/> Other mental disorder <input type="checkbox"/> No formal diagnosis			
K10 Score:		Other Measure (specify): (score)	
Current Medication – Please tick all that apply (if known) <input type="checkbox"/> Anxiolytics <input type="checkbox"/> Antidepressants <input type="checkbox"/> Antipsychotics <input type="checkbox"/> Hypnotics and Sedatives <input type="checkbox"/> Psychostimulants & nootropics <input type="checkbox"/> Mood stabilisers			

PROVIDER OPTIONS: Name of preferred provider or preferred gender of provider (optional)

Insight Clinic Mental Health Services Pty Ltd - Provider Name : Smitha Sugathan.

NB: provider must be a registered with the NORTH WESTERN MELBOURNE PRIMARY HEALTH NETWORK (NWMPHN) CAREinMIND services. See the System of Care for CAREinMIND service and provider list.

CLIENT CONSENT – for service provision, and quality and evaluation purposes

Sharing Information with health providers and On the Line

- ☐ **Yes, I agree to be referred to the CAREinMIND Suicide Prevention Service overseen by NWMPHN. I give consent for my referrer /my GP/paediatrician/psychiatrist to share my personal details with my CAREinMIND provider, On the Line for assessment and allocation purposes, and others involved in my care.**

Client signature:..... Date:

Sharing information with the Commonwealth Department of Health

- ☐ **Yes I consent for my personal details to be shared with the Commonwealth Department of Health for service quality and evaluation purposes.**

Client signature: Date:

REFERRER/GP CONSENT

- ☐ **Yes, I have discussed this referral with my client**

Referrer/ GP Signature:..... Date:.....

GLOSSARY: CAREinMIND™ Mental Health Services

CAREinMIND™ prioritises referrals for individuals who live, work or study in the North Western Melbourne PHN catchment. Similarly, referrals may be prioritised for general practitioners, psychiatrists, paediatricians who practice in the catchment.

CAREinMIND™ Suicide Prevention Support Service - Suicide prevention services provide a rapid and intensive response to individuals at heightened risk of suicide. Contact occurs within 24 hours of referral and the first session of care is generally provided within 72 hours of intake to the service. Note: this is not a crisis service. Available to all ages.

For more information visit: nwmpnhn.org.au/health-systems-capacity-building/careinmind/