

Adelaide Primary Mental Health Care Services (PMHCS)

Item 2715/2717/2701/2700



An Australian Government Initiative

Please note these details **MUST** be provided before the Mental Health Treatment Plan will be accepted by the PMHCS Central Referral Team for allocation to a service provider: Patient details, GP Details, Problem, diagnosis, Risk Assessment, Patient Consent and GP signature

Step 1: Patient Assessment

Patient Details *(must complete)*

| | | | |
|--|--|---|-----------------------------|
| Name: | | Outcome Tool Results: K10/DASS (please circle) | |
| Address: | | Phone Number: | |
| DOB: | | Gender: | |
| Referral Date: | | Medicare No# | |
| Does the patient identify as Aboriginal or Torres Strait Islander? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is the patient from a Culturally and Linguistically Diverse background? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does the patient have a My Health Record? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Patient Demographics

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| Has the patient ever received specialist mental health care? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Language spoken at home: <input type="checkbox"/> English <input type="checkbox"/> Italian <input type="checkbox"/> Greek <input type="checkbox"/> Cantonese <input type="checkbox"/> Mandarin <input type="checkbox"/> Arabic <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other please specify _____ |
| How well does the patient speak English: <input type="checkbox"/> Very Well <input type="checkbox"/> Well <input type="checkbox"/> Not Well <input type="checkbox"/> Not at All |
| Does the patient require an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does the patient live alone: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, with whom _____ |
| Is the accommodation: <input type="checkbox"/> Stable <input type="checkbox"/> Unstable |
| Country of birth: _____ Nationality: _____ |
| Employment Status: <input type="checkbox"/> Student <input type="checkbox"/> Unemployed <input type="checkbox"/> Employed full time <input type="checkbox"/> Employed part time <input type="checkbox"/> Home Duties <input type="checkbox"/> Other |
| Pension or Health Card Status: <input type="checkbox"/> Aged <input type="checkbox"/> Disability <input type="checkbox"/> Repatriation <input type="checkbox"/> Unemployment Benefit <input type="checkbox"/> Sickness Benefit <input type="checkbox"/> Other |
| Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> De facto <input type="checkbox"/> Widowed |
| Does the patient have any dependents: <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, please tick <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Other |

Psychosocial assessment: (e.g. childhood, substance abuse, relationship history, coping with previous stressors)

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Eligibility Criteria for Primary Mental Health Care Services (please tick all that is applicable)

- low income
 Homeless
 CALD
 Aboriginal or Torres Strait Islander
 LGBTQI
 Socially Isolated
 New and emerging populations
 Perinatal
 Comorbid presentation
 Risk of suicide and self-harm
 Underserved group
 Unable to access Better Access.

Mental Status Examination:

| | |
|--|---|
| Appearance and General Behaviour <input type="checkbox"/> Normal <input type="checkbox"/> Other: | Mood (Depressed/Labile) <input type="checkbox"/> Normal <input type="checkbox"/> Other: |
| Thinking (Content/Rate/Disturbances) <input type="checkbox"/> Normal <input type="checkbox"/> Other: | Affect (Flat/Blunted) <input type="checkbox"/> Normal <input type="checkbox"/> Other: |
| Perception (Hallucinations etc.) <input type="checkbox"/> Normal <input type="checkbox"/> Other: | Sleep (initial Insomnia/Early Morning Wakening) <input type="checkbox"/> Normal <input type="checkbox"/> Other: |
| Cognition (level of Consciousness/Delirium/Intelligence) <input type="checkbox"/> Normal <input type="checkbox"/> Other: | Appetite (Disturbed Eating Patterns) <input type="checkbox"/> Normal <input type="checkbox"/> Other: |
| Attention/Concentration <input type="checkbox"/> Normal <input type="checkbox"/> Other: | Motivation/Energy <input type="checkbox"/> Normal <input type="checkbox"/> Other: |
| Memory (Short and Long Term) <input type="checkbox"/> Normal <input type="checkbox"/> Other: | Judgement (ability to make rational decisions) <input type="checkbox"/> Normal <input type="checkbox"/> Other: |
| Insight <input type="checkbox"/> Normal <input type="checkbox"/> Other: | Anxiety Symptoms (Physical & Emotional) <input type="checkbox"/> Normal <input type="checkbox"/> Other: |
| Orientation (Time/Place/Person) <input type="checkbox"/> Normal <input type="checkbox"/> Other: | Speech (Volume/Rate/Content) <input type="checkbox"/> Normal <input type="checkbox"/> Other: |
| Other Mental Health Professionals involved in patient care | |
| Name/Profession: | Contact number: |
| | |
| | |

GP Details

| | | | |
|-----------------|--|-----------------------|--|
| Name: | | Practice Name: | |
| Address: | | Phone: | |

Presenting Problem/ Provisional diagnosis (*must complete*)

| Number 1 | Number 2 | Number 3 |
|----------|----------|----------|
| | | |

Risk Assessment (*must complete*)

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|-------------------------------|--|-----------------------|--|
| Suicidal ideation: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Suicide intent | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Current suicidal plan: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Risk to others | <input type="checkbox"/> Yes <input type="checkbox"/> No |

GUIDE TO ABOVE RISK ASSESMENT OUTCOME:

If **YES** to one or more of the above Risk Assessment questions please contact your local service provider.

If **NO** to the above Risk Assessment Clinical Triage will determine the service provider based on information supplied in this referral.

Other Comments

| | |
|--|-------------------|
| Medications: | Allergies: |
| Relevant physical and mental examination: | |

Patient history

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|---|
| <p>Include relevant biological, psychological and social history including any family history of mental disorders and any relevant substance abuse or physical health problems.</p> |
|---|

Step 2: Mental Health Care Plan

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|---|------------------|------------------|
| Key family contact/support details/phone: | | |
| | | |
| Emergency Care/relapse prevention: | | |
| | | |
| Initial action plan: | | |
| GOAL | TREATMENT | REFERRALS |
| | | |
| Review date: (Add a recall in clinical software for 4 months after the <u>Plan</u> date) | | |
| Copy of Mental Health Treatment Plan given to Patient: | | |

Patient Consent to release information (must complete)

I, _____ (patient name-please print clearly) understand that this MHTP is being used as a referral for the provision of mental health services. This process involves an assessment and the development of a plan for treatment. I agree to be part of the process with the knowledge that:

- My medical history will be shared with the GP and Clinician of the service chosen/and personnel of the chosen service where relevant;
- The information collected is private and will be kept confidential unless agreed upon by all parties to be shared;
- My GP has explained to me the reasons for seeking counselling/therapeutic input;
- No Medico Legal Reports will be provided;
- I understand that my treatment will be monitored and communicated between my treatment team.
- All personal information gathered will remain confidential and secure with my treating team and within the clinical management system hosted by the funding body APHN

Therefore, in complying with the principles governing provision of this service we seek your consent.

Patient signature _____

Date: _____

GP Signature _____

Date: _____

For patients under 16 years:

Carer name: _____

Carer signature _____

**PLEASE FAX YOUR COMPLETED REFERRAL FORM TO THE PMHCS CENTRAL REFERRAL TEAM ON:
1300 580 249**