Country & Outback Health

Primary Mental Health Referral Form

*Please fax all referrals to* ***08 8312 2506*** or email to ***admin@cobh.org.au***

***All items indicated with******\*******are required fields***

**\* Client Details**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **\* Name:** |  | | | **\* D.O.B:** |  |
| **\* Gender:** | Male  Female  Identifies as other | | | | |
| **\* Address Residential:** |  | | | | |
| **\* Address Postal:** |  | | | | |
| **\* Suburb:** |  | | | **\* Post Code:** |  |
| **\* Phone:** |  | **Mobile:** |  | **Work:** |  |
| **\* Health Care Card:** | Yes  No Card Number: | | | | |
| **\* Underserviced groups** | Aboriginal or Torres Strait Islander  Yes  No | | | | |
|  | Perinatal Period  Yes  No  Estimated Due Date: or Actual Birth Date of Child: | | | | |
|  | Experiencing or at risk of homelessness  Yes  No | | | | |
|  | Culturally and linguistically diverse background (CALD)  Yes  No | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **\* GP Practice Name:** |  | | |
| **\* GP Practice Address:** |  | | |
| **\* Name of the GP:** |  | **\* GP Provider Number** |  |
| **\* Practice Phone Number:** |  | **\* Practice Fax Number:** |  |

**\* Mandatory Referral Data**

|  |  |  |  |
| --- | --- | --- | --- |
| **\* Prior Specialist Mental Health Treatment:** | Yes  No | **\* Provisional Diagnosis:** | Adjustment Disorder  Affective Disorder  Anxiety Disorder  Bipolar Disorder  Personality Disorder  Schizophrenia  Somatic Disorder  Other Mental Health Disorder  Other Psychotic Disorder |
| **\* Is the person a low-income earner?**  *(Has a health care card)* | Yes  No |

**\* Mental Health Treatment Plan or attach a copy of a completed mental health treatment plan**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Diagnosis/Presenting Problem** | **Goal**  *(reduce symptoms, improve functioning)* | | | | **Action / Task**  *(psychological or pharmacological treatment, referral, engagement of supports)* | |
| 1. |  | | | |  | |
| 2. |  | | | |  | |
| 3. |  | | | |  | |
| **Reason for referral:** |  | | | | | |
| **\* Psychiatric History:**  *(Personal mental health history, name of psychiatrist, details of previous inpatient admissions, engagement with State Mental Health Service)* | Nil | | | | | |
| **\* Medications:** | ☐ Antipsychotics  ☐ Anxiolytics  ☐ Hypnotics and sedatives  ☐ Antidepressants  ☐ Psychostimulants and nootropics | | | | | |
| **Outcome Measures:**  *Please attach a copy of the completed tool* | **K10+** | **DASS 21** | | | | **EPDS (perinatal)** |
| **Result/s:** |  | **D** | **A** | **S** | |  |
|  |  |  | |

**Mental State Examination** *(If other please describe)*

|  |  |
| --- | --- |
| **Mood:**  Normal Other : | **Appearance & General Behaviour**  Normal Other : |
| **Thinking:**  Normal Other : | **Affect**  Normal Other : |
| **Perception**  Normal Other : | **Sleep**  Normal Other : |
| **Cognition**  Normal Other : | **Appetite**  Normal Other : |
| **Attention /Concentration**  Normal Other : | **Motivation/Energy**  Normal Other : |
| **Memory**  Normal Other : | **Judgement**  Normal Other : |
| **Insight:**  Normal Other : | **Anxiety Symptoms**  Normal Other : |
| **Orientation:** (time/place/person)  Normal Other : | **Speech**  Normal Other : |
| **Any other comments:** | |

**\* Risk Assessment**

|  |  |  |  |
| --- | --- | --- | --- |
| **\* Suicidal Ideation:** | Yes  No | **\* Suicidal Intent / Plan:** | Yes  No |
| **\* Previous Attempt:** | Yes  No | **\* Access to Methods:** | Yes  No |
| **\* History of Self Harm:** | Yes  No | **\* Risk to Others:** | Yes  No |
| **\* If yes to any of the above provide relevant details:** |  | | |
| **Identify and provide details of any protective factors or key support contacts:** |  | | |
| **Provided numbers for immediate assistance:** | Yes  No E.g., Rural & Remote Mental Health Service **13 14 65,** Life Line **13 11 14** | | |
| **Date of follow up GP appt:** |  | | |
| **Forensic History:** |  | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Medical Conditions:** | Type 1 Diabetes  Type 2 Diabetes  Chronic pain condition  Cardiovascular disease  Phx Myocardial infarction  Metabolic syndrome  Other chronic condition, please list ………………………………………………………………………………………. | | | | | |
| **Substance Use** | Alcohol  Tobacco  Alcohol dependence  Cannabis  Methamphetamine  Other illicit substances | | | | | |
| **Medical Status:** | Body Mass Index: |  | Blood Pressure: |  | Immunisation Status: |  |
| **History of Abuse:** | Sexual  Physical  Emotional | | | | | |
| **Other relevant**  **Personal / Social History:** |  | | | | | |
| **Other Recent Investigations:** |  | | | | | |

**Relevant History**

|  |  |
| --- | --- |
| **A copy of the Mental Health Treatment Plan was provided to the Patient:** | ☐ Yes ☐ No |

|  |  |
| --- | --- |
| *The GP has explained the purpose of my Mental Health Treatment Plan and I give permission for my GP to discuss my medical history and diagnosis with other mental health providers who may contribute towards my care.* | |
| **\*Patient Signature:** | **Date:** |
| **\*GP Signature:** | **Date:** |

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**Kessler 10 Plus (K10+)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | **Date:** |  | **TOTAL** |

*For all questions, please select the appropriate response on how you have felt by placing an ✓ in the selected box for each response.*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | None of the time | A little of the time | Some of the time | Most of the time | All of the time |
| 1 | In the last 4 weeks, about how often did you feel tired out for no good reason? | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| 2 | In the last 4 weeks, about how often did you feel nervous? | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| 3 | In the last 4 weeks, about how often did you feel so nervous that nothing could calm you down? | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| 4 | In the last 4 weeks, about how often did you feel hopeless? | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| 5 | In the last 4 weeks, about how often did you feel restless or fidgety? | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| 6 | In the last 4 weeks, about how often did you feel so restless you could not sit still? | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| 7 | In the last 4 weeks, about how often did you feel depressed? | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| 8 | In the last 4 weeks, about how often did you feel that everything is an effort? | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| 9 | In the last 4 weeks, about how often did you feel so sad that nothing could cheer you up? | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| 10 | In the last 4 weeks, about how often did you feel worthless? | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |

Office use only

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **1** | **2** | **3** | **4** | **5** |
| **✓** |  |  |  |  |  |
| **Score** |  |  |  |  |  |

*The next few questions are about how these feelings may have affected you in the* ***last four weeks.*** *You need not answer these questions if you answered, ‘None of the time’ to all of the ten questions about your feelings.*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 11. | In the last 4 weeks, how many days were you TOTALLY UNABLE to work, study or manage your day to day activities because of these feelings? | \_\_\_ | (Number of days) | | | |
| 12. | [Aside from those days], in the last 4 weeks, HOW MANY DAYS were you able to work or study or manage your day to day activities, but had to CUT DOWN on what you did because of these feelings? | \_\_\_ | (Number of days) | | | |
| 13. | In the last 4 weeks, how many times have you seen a doctor or any other health professional about these feelings? | \_\_\_ | (Number of days) | | | |
| 14. | In the last 4 weeks, how often have physical health problems been the main cause of these feelings?? |  |  |  |  |  |
|  | None of the time 🞎  A little of the time 🞎  Some of the time 🞎  Most of the time 🞎  All of the time 🞎 |  | | | | |