

GP Referral Form



headspace Armadale is a free, youth-friendly and confidential service available to young people aged 12 – 25 years, in the south east metropolitan region of Perth. **headspace** Armadale brings together a range of co-located community-based and government agencies, to provide a holistic service as a “one-stop-shop” for young people. We offer information, intake, assessment and referral.

The services available at **headspace** Armadale include:

- Youth Friendly General Practitioner/s
- Youth Support Workers
- Sexual health clinic
- Drug and alcohol outreach worker
- MBS & ATAPS Psychological services
- Vocational support worker

How to refer

Professional Referral

- Referrals accepted from GP’s, Allied Health Professionals, community-based agencies and educational institutions
- Where available, GP’s should include a copy of the client’s Mental Health Treatment Plan

Client Details

| | | | |
|---|---|--|------------|
| Date of Referral | | DOB / / | Age |
| Name | | Gender | |
| Address | | | |
| Email | Mobile | Home Phone | |
| Medicare No. | Reference No. | Expiry Date: | |
| Are there any safety concerns when contacting the patient by phone/mail? | | | |
| Consent to contact young person via: (e.g. confirm appointments etc.) | | | |
| Mobile: <input type="checkbox"/> Yes <input type="checkbox"/> No | Text: <input type="checkbox"/> Yes <input type="checkbox"/> No | Voicemail: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Email: <input type="checkbox"/> Yes <input type="checkbox"/> No | Mail: <input type="checkbox"/> Yes <input type="checkbox"/> No | At home: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Preferred method of contact (this can change and other arrangements can be made): | | | |
| Language spoken at home? | | | |
| Ability to speak English? <input type="checkbox"/> Very well <input type="checkbox"/> Well <input type="checkbox"/> Not well <input type="checkbox"/> Not at all | | Preferred Language | |
| What is the client’s cultural background? <input type="checkbox"/> Aboriginal <input type="checkbox"/> TSI <input type="checkbox"/> Other <input type="checkbox"/> Unknown | | | |
| Who does the young person live with? | | | |
| Education/employment status? | | | |
| Is the client aware and consented to the referral and wanting treatment? | | | |
| Next of Kin (MUST be completed if client is under 16 unless mature minor process followed) | | | |
| Next of Kin name | | Mobile number | |
| Relationship to client | | Home number | |
| Is the young person’s parent/guardian aware that this referral has been made? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |

Reason for Referral

Presenting Issues (please include here any information which may be useful as background information to assist with the referral e.g. mental health, drug and alcohol, vocational/educational, physical health, including past/current risk assessments)

- Mental health
- Situational
- Physical health
- Sexual health
- Social support
- Alcohol/drugs
- Family support

Eating

Vocational/education
 Home/environment

Friendships

Relationships/sexuality

Mental health diagnosis (if relevant)

(Please attach copy of current Mental Health Treatment Plan if available)

Duration of presenting problem

Recent Stressors Are there any legal proceedings pending? (please note headspace is unable to provide opinion re: legal matters or supporting documents)

Client History (Relevant biological, psychological, physical and social history, including family history)

Relevant medications:

Risk to self or others (include self-harm/suicide attempts, violence, threats of violence)

PLEASE NOTE: headspace does not provide crisis or acute care, if in crisis please refer to the closest Emergency Department or call the Mental Health Emergency Response Line (MHERL) on 1300 555 788

Other Care Providers Involved (Previous/Current) (is the young person linked in with any other services? For example CAMHS)

Admissions to hospital related to mental health?

If so, how many?

Referrer Details

Name Relationship to the client

Address

Organisation Contact Number

Client's GP (if not the referrer):

Name Practice

Address

Consent Details

Please indicate who is consenting to collection, use and disclosure of personal health information:

Adult client Adolescent client (aged 16 or over) Parent/guardian Mature minor

All information will be treated confidentially and will not be used for any other purposes that what is stated in the full consent form (signed during the first appointment). I am aware that this referral is being made. I understand I can withdraw from this service at any time. The client has been made aware of this referral.

Client name Client signature Date

Parent/guardian name Parent/guardian signature Date

FAX THIS REFERRAL TO HEADSPACE ARMADALE ON 9393 0399 or email to referrals@headspacearmadale.com.au

Please note that headspace Armadale does not provide crisis or acute care mental health services. For mental health emergencies contact the Mental Health Emergency Response Line on 1300 555 788.

GP Referral Form



Please use this MHCP or attach your own

| GP MENTAL HEALTH TREATMENT PLAN (MBS ITEM NUMBER 2715/2717 or 2700/2701) | | | |
|---|---|--|--|
| Patient's Name | | Date of Birth | |
| Address | | Phone | |
| GP Name/Practice Provider Number | | | |
| PRESENTING ISSUE(S) What are the patient's current mental health issues | | | |
| PATIENT HISTORY Relevant biological, psychological, physical social history including family history of mental disorders and any relevant substance abuse | | | |
| MEDICATIONS (attach information if required) | Is the patient receiving psychotropic medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify below <input type="checkbox"/> Benzodiazepines & Anxiolytics <input type="checkbox"/> Antidepressants <input type="checkbox"/> Phenothiazines & Tranquilisers <input type="checkbox"/> Mood Stabilisers | | |
| PREVIOUS MENTAL HEALTH CARE | Has the patient ever received specialist mental health care before (public/private, medical/allied health)? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please specify below | | |
| OTHER RELEVANT INFORMATION | <p><i>Are there any legal proceedings pending? (please note InFocus is unable to provide opinion re: legal matters or supporting documents)</i> <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please specify</p> <p><u>For perinatal referrals only:</u> Due birth date: _____ Actual birth date: _____</p> | | |
| RESULTS OF MENTAL STATE EXAMINATION Record after patient has been examined | Appearance and Behaviour <input type="checkbox"/> Normal <input type="checkbox"/> Other | Mood (Depressed/Labile) <input type="checkbox"/> Normal <input type="checkbox"/> Other | |
| | Thinking (Content/Rate/Disturbance) <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) <input type="checkbox"/> Normal <input type="checkbox"/> Other | Appetite (Disturbed Eating Patterns) <input type="checkbox"/> Normal <input type="checkbox"/> Other | |

GP MENTAL HEALTH TREATMENT PLAN (MBS ITEM NUMBER 2715/2717 or 2700/2701)

| | | | |
|---|---|---|--|
| DIAGNOSIS | ICD-10 Primary care diagnostic categories <input type="checkbox"/> F1 – Alcohol & Drug Use <input type="checkbox"/> F2 – Psychotic disorders <input type="checkbox"/> F3 – Depression <input type="checkbox"/> F4 – Anxiety <input type="checkbox"/> F5 – Unexplained somatic complaints <input type="checkbox"/> Unknown <input type="checkbox"/> Other | | |
| PATIENT NEEDS/MAIN ISSUES | GOALS Record the mental health goals agreed to by the patient and GP and any actions the patient will need to take | | |
| TREATMENTS Treatments, actions and support services to achieve patient goals | REFERRALS | | |
| Referred for which strategies: <input type="checkbox"/> Diagnostic Assessment <input type="checkbox"/> Psycho-education <input type="checkbox"/> Interpersonal therapy <input type="checkbox"/> Narrative Therapy <input type="checkbox"/> Family Therapy (perinatal referrals only) <input type="checkbox"/> Other (<i>please specify</i>) | Cognitive-behavioural therapy (CBT): <input type="checkbox"/> Behavioural Interventions <input type="checkbox"/> Cognitive Interventions <input type="checkbox"/> Relaxation Strategies <input type="checkbox"/> Skills training <input type="checkbox"/> Other CBT interventions | | |
| CRISIS/RELAPSE If required, note the arrangements for crisis intervention and/or relapse prevention | | | |
| COMPLETING THE PLAN On completion of the plan, the GP is to record that s/he has discussed with the patient: <input type="checkbox"/> The assessment; <input type="checkbox"/> All aspects of the plan, including referrals to other providers <input type="checkbox"/> Agreed date for review <input type="checkbox"/> Offered a copy of the plan to the patient and/or their carer (if agreed by patient) | | DATE MENTAL HEALTH TREATMENT PLAN COMPLETED REVIEW DATE (initial review 4 weeks to 6 months after completion of plan) | |
| | 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 and 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 | |
| RISKS AND CO-MORBIDITIES | Suicidal Ideation <input type="checkbox"/> Yes <input type="checkbox"/> No Current Plan <input type="checkbox"/> Yes <input type="checkbox"/> No | Suicidal Intent <input type="checkbox"/> Yes <input type="checkbox"/> No Risk to Others <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| OUTCOME TOOL USED E.g. K10, DASS-21 | RESULTS (<i>please attach with referral</i>) | | |