SEMPHN Mental Health Referral Form (Child)

Date: Reset Form **semphn.org.au/access**

Patient Details	
Full Name:	Level of patient mental health need: ◯ At risk ◯ Mild ◯ Moderate ◯ Severe
Date of Birth:	Health Care Card: ◯ Yes ◉ No
Gender: ◯ Female ◯ Male ◯ Other	NDIS participant: ◯ Yes ◉ No
Phone (Mobile):	ATSI status: ◉ Neither Aboriginal or Torres Strait Islander origin ◯ Aboriginal but not Torres Strait Islander origin ◯ Torres Strait Islander but not Aboriginal origin ◯ Both Aboriginal and Torres Strait Islander origin ◯ Not Stated / Inadequately described
Phone (Home):	Interpreter required: ◯ Yes ◉ No
	Language spoken at home:
Home Address: _____ Suburb_____ Postcode_____ State VIC	Treatment Location Preference (LGA): ◯ Bayside ◯ Glen Eira ◯ Cardinia ◯ Kingston ◯ Casey ◯ Mornington Peninsula ◯ Dandenong ◯ Port Philip ◯ Frankston ◯ Stonnington

Referrer Details	
Full Name:	Organisation:
Phone:	Fax:
Address: _____ Suburb_____ Postcode_____ State VIC	

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Support Person Details	
Full Name:	Phone:
Relationship with Patient:	Phone (Mobile):

Assessment

Alerts

(consider any alerts relevant to this referral)

Reason for referral

Telehealth consideration

Please advise: Does the patient consent to receiving support via telehealth? Yes ◯ No ◯

Outcome Tool

Name:

◯ HoNOSCA (Health of the Nation Outcome Scales for Children and Adolescents)

◯ CGAS (Children's Global Assessment Scale)

◯ FIHS (Factors Influencing Health Status)

Score:

Current Medications

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Patient History and Status
Diagnosis History
Family History
Social History
Mental Health History
Personal History
Substance Use

Mental State Examination
(consider appearance and general behaviour; mood; thinking; affect; perception; sleep; cognition; appetite; attention and concentration; motivation and energy; memory; judgement; insight; anxiety symptoms; orientation, speech)

Risk Assessment
(consider suicidal ideation; suicide history; suicidal intent, risk of self-harm; risk to others)

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Patients who are at **acute** or **immediate risk** of suicide or self-harm should be referred to an Emergency Department / Acute Mental Health service

Emergency Care Plan: Important Numbers			
Mental Health Advice Line	1300 280 737	Suicide Line	1300 651 251
Youth Blue	1300 224 636	Suicide call back service	1300 659 467
OCD & Anxiety Help Line	1300 269 438	Lifeline	13 11 14
Domestic Violence Line GP	1800 737 732	DirectLine (Drug & Alcohol)	1800 888 236
After Hours Support Line	1800 022 222	Also good for carers or support persons	
Child Protection Helpline	13 21 11	Parent Line	1300 130 052
Kids Helpline	1800 55 1800	Beyond Blue	1300 224 636
Family Referral Service	1800 066 757	Emergency	000

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Consent

I, , give consent for:

1. The South Eastern Melbourne PHN (SEMPHN) to seek, collect and share information about my health and wellbeing and for this information to be disclosed to the health provider(s) to whom I will be referred:

(●) Yes ( ) No

Support Person Signature (on behalf of the patient)	Date

I, , have discussed the proposed referral(s) with the patient, and I am satisfied that the patient understands the proposed uses and disclosures, and the patient has provided their informed consent for these proposed uses and disclosures.

Referrer Signature	Date

Fax this referral form to SEMPHN Access & Referral on

Fax: 1300 354 053

For enquiries call SEMPHN Access & Referral on **1800 862 363** or visit **semphn.org.au/access**

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