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CFCO010 - Midwest Mental Health Portal Referral Form

Eligibility Criteria

- Health Care Card holder
- Permanent resident of Midwest region
- Not in crisis or in need of urgent assistance

Patient Details

Patient Name:		D.O.B:
Patient Address:		
Home Phone:	Mobile:	Date of Referral:
Gender: Male ☐ Female ☐ Other:	Interpreter required: Yes ☐ No ☐	Language:
Aboriginal ☐	Torres Strait Islander ☐	Both Aboriginal & Torres Strait Islander ☐
Parent/Guardian Name (if under 16) or NoK:		Phone:
Prior mental health care: Yes ☐ No ☐	Has the patient's Mental Health Care Plan been billed? Yes ☐ No ☐	
Health Care Card No:	Expiry:	
Mental Health Care Plan attached: Yes ☐ No ☐		

GP / Referrer Details

Name:	Phone:
Address:	Practice/Organisation:

Mental Health Diagnosis

☐ Alcohol/drug use ☐ Psychotic Disorder ☐ Depression ☐ Unexplained Somatic Disorder

☐ Anxiety ☐ Childhood behavioral disorder ☐ Other:

☐ Severe & persistent mental illness ☐ Mild to moderate mental illness

☐ Experiencing suicidal ideation or chronic self-harming behaviour

Current Psychotropic Medications

☐ Mood Stabilizers ☐ Anti-psychotic & Tranquilizers ☐ Antidepressants ☐ Benzodiazepines & Anxiolytics

Reason for Referral

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Mental Health / Medical History
Other Agency / Service Involvement
Outcome Tool
☐DASS 42 ☐DASS 21 ☐ K10 ☐SDQ (attached) Score:

☐ I consent to 360 Health + Community discussing my referral with partner agencies if appropriate.

Patient Signature:

Official Document Control			
Version Number	**Purpose/change**	**Approver**	**Date**
1	Revision	Executive Manager	2/09/2019