

## Midwest Mental Health Portal Referral Form

### Eligibility Criteria

- Experiencing financial hardship
- 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 <input type="checkbox"/> Female <input type="checkbox"/> Other:	Interpreter required: Yes <input type="checkbox"/> No <input type="checkbox"/>	Language:
Aboriginal <input type="checkbox"/>	Torres Strait Islander <input type="checkbox"/>	Both Aboriginal & Torres Strait Islander <input type="checkbox"/>
Parent/Guardian Name (if under 16) or NoK:		Phone:
Prior mental health care: Yes <input type="checkbox"/> No <input type="checkbox"/>	Has the patient's Mental Health Care Plan been billed? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Health Care Card No:		Expiry:
Mental Health Care Plan attached: Yes <input type="checkbox"/> No <input type="checkbox"/>		

### 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

--

This document is protected by copyright. No part of this document may be reproduced, adapted, transmitted or stored in any form by any process (electronic or otherwise) without the specific written consent of Quality. All rights are reserved.

Document Name: Midwest MH Portal Referral Form	Updated: 20/09/2023	CGMHF010	Version: 1
Authorised: Risk, Quality and Governance Manager	Review: 20/09/2023	Page:	1 of 2

**This document is CONTROLLED. If printed, this document is UNCONTROLLED.**

**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:**

--

This document is protected by copyright. No part of this document may be reproduced, adapted, transmitted or stored in any form by any process (electronic or otherwise) without the specific written consent of Quality. All rights are reserved.

Document Name: Midwest MH Portal Referral Form	Updated: 20/09/2023	CGMHF010	Version: 1
Authorised: Risk, Quality and Governance Manager	Review: 20/09/2023	Page:	2 of 2

**This document is CONTROLLED. If printed, this document is UNCONTROLLED.**