Referral Form Psychological Therapy & Clinical Care Coordination

CARE4MH
A PERSON CENTRED MENTAL HEALTH & PHYSICAL WELLBEING PRACTICE

Supported by phn NORTHERN QUEENSLAND
An Australian Government Initiative

This referral form is for the Clinical Care Coordination and Psychological Therapy Programs for people within the Mackay region. CARE4MH is proud to be part of MyndKind, a new and easier way for North Queenslanders to access mental health services and support that best suit their needs. Find out more about MyndKind at https://www.NQPHN.com.au/myndkind

Date of Referral: _____

Services required for: ☐ **Child (0-12)** ☐ **Youth (12-25)** ☐ **Adult (18+)**

If the person has acute mental health needs, refer to Acute Care Team or Child Youth Mental Health Service via 1300 642 255

Please select your recommended service option for the person from the following:

☐ Psychological Therapies

A rapid-access psychological therapy service providing moderate to high-intensity support, delivering person-centred care to enhance mental health and overall wellbeing.

Eligibility requirements that the person meets the following criteria:

- The individual has moderate to high-intensity mental health needs, is experiencing financial hardship, and cannot access any other suitable services.

☐ Clinical Care Coordination

A care coordination approach to provide holistic care and treatment for people with high acuity, severe & persistent mental health needs, which impacts daily function.

Eligibility requirements that the person meets the following criteria:

- Has high intensity mental health needs who is experiencing genuine financial disadvantage and are unable to access another suitable service
- The person experiences severe mental illness with complex needs, including severe episodic illness
- Has at least two or more aspects of their life significantly impacted by mental illness
- Has experienced a hospitalisation for mental health issues in the past, or be at risk of hospitalisation if not supported
- are best supported in primary health care and are not current clients of the HHS mental health services
- are expected to need ongoing treatment of their disorder over a longer period of time, with a review of ongoing needs to be conducted at regular intervals

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Referrer Details

Referrer Name:_____ **Role/Relationship:**_____

Organisation Name:_____ **Provider Number:**_____

Contact Number:_____ **Fax Number:**_____

Referrer Email:_____

Consumer Details

Full Name:_____

Date of Birth:_____ **Gender:** _____

Address:_____

Phone:_____ **Email:**_____

Preferred Contact Method: Phone Email Mail **Do you consent to us contacting you?** Yes No

Health Care Card? Yes No **Pension Card?** Yes No

Dept Veterans Affairs (DVA) Card? Yes No

Proficiency in spoken English: Very Well Well Not Well Not at all

Interpreter required? Yes No **If yes, language:**_____

Emergency Contact

Contact in the event of an emergency or if the referred person is unavailable. If the consumer is a child, provide the details of the legal parent or guardian.

Primary Contact:_____ **Role/Relationship:**_____

Agency:_____ **Phone:**_____

Email:_____

This CARE4MH service is supported by funding from the Australian Government under the PHN Program.

Referral Information

Note: *It is not necessary to complete the Referral Information section if a Mental Health Treatment Plan (MHTP) or Child Treatment Plan (CTP) accompanies this referral document and contains the information below.*

Reason for referral:_____

_____

_____

_____

Is there a mental health diagnosis? Yes No

*If yes, please specify:*_____

_____

Are there health professionals currently involved in the consumer's care? Yes No

If yes, please provide details:_____

Is the individual currently taking medication? Yes No

*If yes, please list medications or attach a medication record:*_____

_____

Is there a history of alcohol and/or drug use? Yes No

*If yes, please provide details:*_____

_____

Is there history of suicide and/or self harm? Yes No

If yes, please provide details: _____

_____

Is there a history of aggression or violence? Yes No.

*If yes, please explain:*_____

_____

Is there a concern regarding safety, vulnerability, and/or domestic violence? Yes No

*If yes, please provide details:*_____

_____

_____

_____

Consent To Share Information

In accordance with the Privacy Act 1988 and the Information Privacy Act 2009, your consent is required for the release of information related to this application.

By signing this form, you consent CARE4MH to collect and share information relevant to your application with relevant Local Health District services, your emergency contact, and other service providers involved in your care. This consent ensures that all parties can collaborate effectively to support your mental health needs.

Do you consent? Yes No

Consumer name (or Legal Parent/Guardian if a child):_____

Consumer signature (or Legal Guardian/Parent if a child):_____ **Date:**_____

The referrer agrees that all information submitted in this referral is an accurate and complete, reflecting the applicant's support needs. This information is essential for Care4MH to effectively fulfill its duty of care to consumers, staff and parter agencies.

Referrer name:_____

Referrer signature:_____ **Date:**_____

What Happens Now

- Email this referral form and any other relevant documents to admin@care4mh.com
- A CARE4MH staff member will contact the person referred to validate the referral, and to schedule an appointment with a mental health clinician.