HEALTHY MINDS

Referral Form

FAX: 1300 853 248

The client **MUST** be in one or more of these **ELIGIBLE GROUPS** to be accepted into the Healthy Minds program **AND** either hold a healthcare card or be currently experiencing financial disadvantage.

❶ **Supporting Information** *A Box must be ticked*			
Currently Financially Disadvantaged	☐ **Yes**	☐ **No**	***IF NO NOT ELIGIBLE FOR SERVICE***
Current Health Care Card	☐ **Yes**	☐ **No**	**Health Care Card Number :**

❷ **Eligible Groups** *A Box must be ticked*		
☐ **Child (up to 12 years)**	☐ **Aboriginal/Torres Strait Islander**	☐ **Homeless, or at risk of becoming homeless**
☐ **Perinatal – 20 weeks pre-birth to 1 year post- birth**	☐ **Cultural and Linguistic Background**	

❸ **Referral Details**	
Date of Referral / /	
Name	**Profession**
GP Provider Number	**Organisation**
Email	**Phone**

❹ **Mental Health Provider Details** *Select option A or B*	
A) Preferred Provider Lucy Van Sambeek	**B) Healthy Minds To Allocate**
Location: Kempsey/Macksville/Bowraville/Nambucca/Coffs H	**Location:**

❺ **Client Details**				
Given Name		**Surname**		**DOB:** / /
Gender:	☐ **Female**	☐ **Male**	**LGBTQI**	☐ **Yes** ☐ **No**
Residential Address:				
Contact Number Home:			**Mobile:**	
Name of emergency contact			**Phone:**	
Living Status	☐ **Lives Alone**	☐ **Lives with others**		☐ **Living Rough/Homeless**
Cultural Background	☐ **Aboriginal**	☐ **Neither Aboriginal or Torres Strait Islander**		☐ **Torres Strait Islander**
Country of Birth:				
Preferred Language:			**Interpreter Required**	☐ **Yes**
English Spoken	☐ **Very Well**	☐ **Not Well**	☐ **Well**	☐ **Not at all**

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❻ Severity of Mental Health Condition

Mental Health Condition -	**Moderate**	☐ **Yes**	☐ **No**	***A Box Must Be Ticked***
If No Selected	**Low** – Refer to New Access Ph:1800 010 630	**Severe/Complex**	Refer to Specialist Mental Health Service	

❼ Outcome Tool & Score

☐ **K10/K5**	**SCORE:**	☐ **EPDS** (Edinburgh Postnatal Depression Scale)	**SCORE:**
☐ **DASS 21**	**SCORE:**	☐ **SDQ** (Strength and difficulties Questionnaire)	**SCORE:**

❽ Primary Diagnosis

Additional information as appropriate

❾ Client Consent

I understand that this referral is for short term, focused, psychological treatment (up to 12 sessions) with an accredited mental health provider.

I consent that my personal details (name, address and phone number) and information about my mental health will be shared with the North Coast Primary Health Network (NCPHN), a Healthy Minds Provider(s) and may also be shared with my General Practitioner. NCPHN will also use this data to: manage the Healthy Minds program; to understand the health needs of our community; and to assess whether we've got the right services in the right places.

NCPHN is committed to providing you with the highest level of service, privacy and confidentiality, and are bound by the *Commonwealth Privacy Act 1988* and the *Privacy Amendment (Private Sector) Act 2000*, which outlines the protection of your personal information.

Client name		Signature		Date	/ /
Parent/Guardian Name **If Client is under the age of 16 years**		Signature		Date	/ /

❿ You may choose to consent to your information being provided by the North Coast Primary Health Network to the Department of Health for use in statistical and evaluation purposes designed to improve mental health services in Australia. I understand that this will include details about me such as date of birth, gender and types of services I use but will not include my name, address or Medicare number.
I understand that my information will not be provided to the Department of Health if I do not give my consent.

☐ **I consent** to my information being provided to the Department of Health