



MR/CR771

Stepped Care Intake and Referral Form

Surname:.....

Given Names:.....

Date of Birth:..... Gender:.....

UR No.:.....

(AFFIX PATIENT LABEL HERE)

MENTAL HEALTH SERVICES via Stepped Care

Upon completion, this form is to be submitted to the Community Health Centre via internal mail or Fax: 5683 9746

Date of Referral: / / [ ] A Mental Health Plan or Child Health & Wellbeing Plan has been completed (if applicable)

Service/s Needed: [ ] Counselling [ ] Social Work

Referrer Name:

Practice/Organisation & Name of Referrer

Practice Address: Postcode:

Priority Groups: [ ] Young person (12 – 25) [ ] Homeless/at risk [ ] Remote [ ] CALD (Culturally & Linguistically Diverse) [ ] Suicide prevention [ ] Carer with Mental Illness [ ] Perinatal [ ] Aboriginal/Torres Strait Islander

Stepped Care Program: [ ] General [ ] Child [ ] Suicide Prevention Services (SPS) [ ] Extreme Climatic Events

Patient Risk Assessment: If you answer YES to any of these, please consider a referral to: Mental Health Triage – Latrobe Regional Hospital (1300 363 322)

Suicide ideation? [ ] Yes [ ] No Is there history of attempts? [ ] Yes [ ] No

Do they have a plan? [ ] Yes [ ] No Do they have access & [ ] Yes [ ] No

Are they at risk to others? [ ] Yes [ ] No means?

Has recent behaviour of your partner or family member towards you made you feel frightened? Or are you afraid of your partner or a family member? [ ] Yes [ ] No

\* Recent defined as in the last 3 months

Client Name: Surname: Given name: Is The Client of Aboriginal And / Or Torres Strait Islander Origin? [ ] Aboriginal [ ] Torres Strait Islander [ ] Both [ ] Neither

Date of Birth:

Address: Postcode: Has the Client Received Mental Health Care Before? [ ] Yes – for the current problem [ ] Yes – for a different problem [ ] No [ ] Unknown

Mobile Number: Diagnosis:

Landline Number: Medication:

Gender: [ ] Male [ ] Female [ ] Intersex [ ] Gender diverse [ ] Transgender Other Conditions/Symptoms That May Influence Client Outcomes and Participation

Does The Client Live on Their Own? [ ] Yes [ ] No

Main Language Spoken at Home: [ ] English [ ] Italian [ ] Cantonese [ ] Greek [ ] Mandarin [ ] Arabic [ ] Vietnamese [ ] Other, specify:

How Well Does the Client Speak English? [ ] Very well [ ] Well [ ] Not well [ ] Not at all [ ] Unknown Please Provide Further Details on The Next Page. It Helps Our Service If as Much Details as Possible Is Provided Within the Referral.

Signature:..... Date:.....

Name/Designation:..... Time:.....



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REFERRAL INFORMATION

Large ruled area for referral information.

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