

Referring Doctor:

Date:

Medical Practitioner Name:
Practice Address:

Phone:

Email:

Fax:

PHN: North PHN South PHN

Preferred contact method: Phone Email Fax

Patient Consent:

I confirm that I have discussed this program with the patient, and that I have obtained their consent for this referral

I confirm the patient consent for voicemail to be left on contact numbers provided

I confirm I have discussed with the patient the option for anonymized data and the patient **select option** to their information being provided to the Department of Health to be used for statistical and evaluation purposes designed to improve mental health services in Australia. I have explained to the patient that this will include details about them such as date of birth, gender and types of services they use but will not include their name, address or Medicare number. I have explained to the patient that their information will not be provided to the Department of Health if they do not give their consent.

Referral Criteria:

- Aged 18 & over
- Severe / Complex Mental Health care needs

Patient Details:

First Name		Email Address	
Last Name		Date of Birth	
Home Address		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Postcode		ATSI Status	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander
State	Western Australia	Mobility / Sensory Impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Proficient in English	<input type="checkbox"/> Yes <input type="checkbox"/> No

Preferred Contact time
Phone number (mobile preferred)

Select preferred contact day/time.
Home:
Mobile:
Name:
Relationship:
Home/Mobile:

Alternative Contact or Next of Kin

Reason for Referral:

Mental Health Treatment Plan attached (this is mandatory for referral)

90 Day GP Review booked with patient on Date: **Select date**

Primary Diagnosis:		
Secondary Diagnosis:		
Medications:		
Known Risks:	<input type="checkbox"/> Risk of Suicide <input type="checkbox"/> Risk of Harm to Self	<input type="checkbox"/> Risk of Harm to Others <input type="checkbox"/> Other Risks

Select ONE care management service

<input type="checkbox"/>	Face 2 Face Care Management	Please direct this referral to Fax: 92583090 Ph: 1800 742 466 Email: MH.Connex@rw.org.au
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Thank you for referring to MH Connex.
We will be in touch after we have completed our assessment.