MH Connext

Referral Form

To be completed by the Medical Practitioner

Referring Doctor: **Date:**

Medical Practitioner Name:		**Phone:**	
Practice Address:		**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	☐ Male ☐ Female ☐ Other
Postcode		ATSI Status	☐ Aboriginal ☐ Torres Strait Islander
State	Western Australia	Mobility / Sensory Impairment	☐ Yes ☐ No
		Proficient in English	☐ Yes ☐ No

Preferred Contact time	Select preferred contact day/time.
Phone number (mobile preferred)	Home:
	Mobile
Alternative Contact or Next of Kin	Name:
	Relationship:
	Home/Mobile:

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:	☑ Risk of Suicide ☑ Risk of Harm to Self	☐ Risk of Harm to Others ☐ Other Risks

Select ONE care management service

☑	**Face 2 Face Care Management**	**Please direct this referral to** Fax: 92583090 Ph: 1800 742 466 Email: Intake@rw.org.au

Thank you for referring to MH Connext.
We will be in touch after we have completed our assessment.

Supported by WA Primary Health Alliance | phn PERTH NORTH, PERTH SOUTH, COUNTRY WA