Connect to Wellbeing

Connect to Wellbeing Referral Form

Servicing people in the North Coast Primary Health Network catchment area, **Connect to Wellbeing** provides an intake, triage and assessment service that facilitates access to the service/s that best support the mental health needs of the individual.

Date of referral _____ **Services required for** ☐ child (0-12) ☐ youth (12-25) ☐ adult (18+)

If the person has acute mental health needs, please refer to public mental health services Acute Care Team or NSW Mental Health Line 1800 011 511

Please select the option considered most appropriate for the person:

☐ **Low Intensity Strategies (New Access)**

This includes psychological interventions delivered via telephone and web-based services.

☐ **Psychological Therapies (formerly known as HEALTHY MINDS)**

For **low income / financially disadvantaged** people with a non-acute moderate mental health condition who would benefit from short-term goal focused psychological strategies

Priority Groups

- ☐ Aboriginal or Torres Straight Islander (ATSI)
- ☐ Homelessness
- ☐ Perinatal
- ☐ Culturally and Linguistically Diverse (CALD)
- ☐ Children under 12
- ☐ Rural/Remote
- ☐ Extreme climactic events

Eligibility requires that (please tick):

- ☐ A Mental Health Treatment Plan (MHTP) or Child Treatment Plan (CTP) is attached, **or** Appendix A is completed.
- ☐ The person has a **low income or is experiencing financial hardship despite income level** (including Health Care Card, Disability Support Pension, no source of income, low income earners).

Exclusion criteria may apply, please contact Connect to Wellbeing if more information is required.

☐ **Suicide Prevention Services - Low to Moderate Suicide Risk**

NOT intended to support people who are at acute and immediate risk.

Where any of the following requirements are indicated, the person will be contacted **within 24hrs** (business days) of the date of referral and offered an appointment **within 72hrs**.

Please select <u>at least one</u> of the options below:

- ☐ After a suicide attempt or self-harm incident, the person has either been discharged from hospital into the care of a GP, or has been released into the care of a GP from an accident and emergency department.
- ☐ The person has presented after an incident of self-harm.
- ☐ The person has expressed strong recent suicidal ideation.
- ☐ The person is considered at increased risk in the aftermath of a suicide.

NB: Please ensure the person has a GP appointment for review within 2 weeks.

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Referrer Details

Referrer name _____ **Provider number** _____

Address _____

Role/ relationship _____ **Email** _____

Phone _____ **Fax** _____

Consumer Details

Full name _____

Preferred name _____ **Date of birth** _____

Gender ☐ Male ☐ Female ☐ Other _____

Street address _____ ☐ No fixed address

Suburb _____ **Postcode** _____

Phone _____ **Mobile** _____

Email _____ **Preferred form of contact** ☐ Phone ☐ Email ☐ SMS

Health Care card/ Pension? ☐ Yes ☐ No **Dept Veterans Affairs (DVA) Card?** ☐ Yes ☐ No

Proficiency in spoken English ☐ Very Well ☐ Well ☐ Not Well ☐ Not At All ☐ N/A

Aboriginal or Torres Straight Islander status ☐ Yes ☐ No ☐ Not stated

Country of birth _____

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 responsible parent or guardian.

Primary contact _____ **Relationship/role** _____

Agency _____ **Phone** _____

Email _____

Consent to Share Information

The Privacy Act requires the applicant to sign this form giving their consent for the release of their information and details.

I give consent for Connect to Wellbeing to seek and share information concerning matters related to this application, with relevant Local Health District services, North Coast Primary Health Network, the emergency contact outlined in this form, and other service providers relevant to this referral.

I consent to my information being used for statistical and evaluation purposes 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.

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

The referrer agrees that all information submitted in this referral is an accurate reflection of the applicant's support needs, is correct with no information withheld and is necessary for Connect to Wellbeing to fulfill its duty of care to consumers, staff and other partner agencies.

Referrer signature _____ **Date** _____

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An Australian Government Initiative

APPENDIX A - Referral Information (where MHTP / CTP does not provide this information)

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It is not necessary to complete Appendix A if a Mental Health Treatment Plan (MHTP) or Child Treatment Plan (CTP) accompanies this referral form and contains the information below.

Reason for referral (perspective of consumer and referrer)

Outcome measures (score) SDQ | K10 | K5

Mental health diagnosis (if known) / symptoms (or at risk of developing mental illness if child under 12)

Medication

Substance use

Other relevant history / factors (e.g. climatic events, disabilities, medical conditions, allergies)

Risk (describe if risk to self, if risk to others)

Health professionals involved in consumer's care (e.g. GP, allied health professional, psychiatrist)

Please attach any other relevant information or assessments if applicable/appropriate.