MindsPlus

MENTAL HEALTH REFERRAL

Fax cover sheet

Please fax completed form to:

MindsPlus

Fax no: (08) 7109 0048

From (referring GP): _____

Practice name: _____

Practice phone no: _____

Date: _____

Number of pages (including cover sheet): ……

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Mental Health Referral

All items indicated with * are required

*** Name:**				*** D.O.B:**	
*** Gender:**	☐ Male ☐ Female ☐ Identifies as other				
Address Residential:					
*** Address Postal:**					
*** Suburb:**				*** Post Code:**	
*** Phone:**		**Mobile:**		**Work:**	
***Email:**					
*** Medicare Card**	Number		Ref	Expiry date	
*** Prior Specialist Mental Health Treatment:** If yes, who provided?	☐ Yes ☐ No		*** Lives alone:** **If no, who with?**	☐ Yes ☐ No	
*** Interventions Requested:**	☐ Diagnostic Assessment ☐ Psycho-Education ☐ Interpersonal Therapy ☐ Narrative Therapy ☐ Mindfulness ☐ Other		***Cognitive Behavioural Therapy (CBT):**	☐ Behavioural Interventions ☐ Cognitive Interventions ☐ Relaxation Strategies ☐ Skills Training ☐ Other	

*** GP Practice Name:**			
*** GP Practice Address:**			
*** Name of the GP:**		*** GP Provider Number**	
*** Practice Phone Number:**		*** Date of Mental Health Treatment Plan:**	

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*Diagnosis/Presenting Problem	Goal *(reduce symptoms, improve functioning)*	Action / Task *(psychological or pharmacological treatment, referral, engagement of supports)*
1.		
2.		
3.		

* **Reason for referral:**	
Psychiatric History: *(Personal and/or Family History)*	
***Medications:**	☐ Antidepressant ☐ Benzodiazepines & anxiolytics ☐ Phenothiazine's & tranquillisers ☐ Mood stabilisers ☐ Other or attach copy of medication list

* **Outcome tool:** Attach a copy of completed tool	K10	DASS 21			Other (please specify)
		D	A	S	
Result/s:					

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Mental State Examination (*If other please provide details in comments)*

Appearance & General Behaviour:					
		Comments			**Comments**
Mood:	☐Normal ☐Other		**Affect:**	☐Normal ☐Other	
Thinking:	☐Normal ☐Other		**Sleep:**	☐Normal ☐Other	
Perception:	☐Normal ☐Other*:*		**Appetite:**	☐Normal ☐Other	
Cognition:	☐Normal ☐Other		**Motivation / Energy:**	☐Normal ☐Other	
Attention / Concentration:	☐Normal ☐Other		**Judgement:**	☐Normal ☐Other	
Memory:	☐Normal ☐Other		**Anxiety Symptoms:**	☐Normal ☐Other	
Insight:	☐Normal ☐Other		**Speech:**	☐Normal ☐Other	
Orientation: (time/place/person)	☐Normal ☐Other		**Any other comments:**		

Relevant Medical History

Medical Conditions/Allergies:						
Relevant Family History:						
Substance Use/Abuse:	Alcohol:		Tobacco:		Other:	
Medical Status:	Body Mass Index:		Blood Pressure:		Immunisation Status:	
History of Abuse:	☐ Sexual ☐ Physical ☐ Emotional *Comments:*					
Personal / Social History:						
Other Recent Investigations:						

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*** Risk Assessment**

*** Suicidal Ideation:** If yes provide further details below	☐ Yes ☐ No	*** Suicidal Intent / Plan:** If yes provide further details below	☐ Yes ☐ No
*** Previous Attempt:** If yes provide further details below	☐ Yes ☐ No	*** Access to Methods:** If yes provide further details below	☐ Yes ☐ No
*** History of Self Harm:** If yes provide further details below	☐ Yes ☐ No	*** Risk to Others:** If yes provide further details below	☐ Yes ☐ No
*** Lives Alone:**	☐ Yes ☐ No	*** Drug or Alcohol use:**	☐ Yes ☐ No
*** If yes to any of the above provide relevant details:**			
Identify and provide details of any protective factors or key support contacts:			
Provided numbers for immediate assistance:	☐ Yes ☐ No E.g., Rural & Remote Mental Health Service **13 14 65** Life Line **13 11 14**		
Date of follow up GP appointment:			
Forensic History:			

Proposed Follow up Plan

Proposed date for mental health review (between 4 weeks – 6 Months):	
Follow up / Relapse Prevention Plan:	
Emergency Care:	
Patient Education Provided:	☐ Yes ☐ No
Copy of MH Treatment Plan provided to Patient:	☐ Yes ☐ No

The GP has explained the purpose of my Mental Health Treatment Plan and I give permission for my GP to discuss my medical history and diagnosis with other mental health providers who may contribute towards my care.

GP Signature:	**Patient Signature:**