cohealth care for all

phn NORTH WESTERN MELBOURNE An Australian Government Initiative

Cohealth Western Psychosocial Support Service Referral Form

Date:

Eligibility Criteria (Must be completed)

- ☐ Severe episodic mental illness with associated impact on Psychosocial functioning
- ☐ Would benefit from time limited psychosocial support
- ☐ Not eligible for or assisted by NDIS*
- ☐ Not a current consumer of Partners in Recovery (PIR) / Personal Helps and Mentor Services (PHaMS) / Day to day living (D2DL) services
- ☐ Not currently supported or eligible for local hospital network funded Psychosocial support service
- ☐ Lives or works within the Western catchment (Brimbank, Melton, Maribyrnong, Wyndham, Hobsons Bay and Moorabool LGAs)

*NDIS application declined

1. REFERRER DETAILS

Referrer name:_______________________ Relationship to Consumer: _______________

Organisation:____

Address:____

Suburb:_______________________________ Postcode:_________________

Phone:_______________________ Fax: ________

2. CONSUMER DETAILS

First Name:_______________________ Surname:_______________________

DOB:___________ Gender:__________ Phone:_______________________

Email:____

Address:____

Suburb:_______________________________ Postcode: _______________

☐ Aboriginal ☐ Torres Strait Islander background ☐ Culturally and Linguistically Diverse Background

Country of Birth:____________ Interpreter Required (Language/Auslan):_______________

Income Source:____________ Mobility/Disability Needs: _______________________

Homelessness: ◯ Yes ◯ No Comments (including at risk): ___________________

NDIS package declined ◯ Yes ◯ No - person ineligible for service

Comments: ____

3. EMERGENCY CONTACT

If the consumer is a child, please write details of the parent or guardian who is responsible for decisions about treatment.

First Name:_______________________ Surname:_______________________

Gender:_______________ Relationship to Consumer: _______________________

Phone:_______________________ Email: _______________________

Email this completed form to mh@cohealth.org.au

For any queries, call 9448 6880

4. CONSUMER INFORMATION

Note: Only complete this section if this information has not been provided in a supporting documentation

Presenting Issues and reason for referral:
Formal and informal support in place:
Mental Health Diagnosis (if known):
Medication (if known):
Relevant Medical History:
Substance Use:
Other Impacting factors (including risk factors):

Please attach any relevant/supporting documentation: Mental Health Care Plan, Assessment notes/Outcome measure/Discharge summary

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RISK ASSESSMENT (MUST BE COMPLETED)

If your consumer is presenting in an acute psychiatric crisis or risk is high, please call your local area mental health service

Current Suicidal Thoughts: ◯ **No** ◯ **Yes** : ______________________________
Current Suicidal Plan: ◯ **No** ◯ **Yes** : ______________________________
Current Suicidal Intent: ◯ **No** ◯ **Yes** : ______________________________

Recent Suicide attempt in the last three months? ☐ **Yes** ☐ **No**

Relevant History: ______________________________

Suicide Risk Level: ◯ **Not Apparent** ◯ **Low** ◯ **Medium** ◯ **High**

Current Self Harm Thoughts: ◯ **No** ◯ **Yes** : ______________________________
Current Self Harm Plan: ◯ **No** ◯ **Yes** : ______________________________
Current Self Harm Intent: ◯ **No** ◯ **Yes** : ______________________________
Current behaviours: ______________________________
Relevant History: ______________________________

Self-Harm Risk Level: ◯ **Not Apparent** ◯ **Low** ◯ **Medium** ◯ **High**

Current Harm to Others Thoughts: ◯ **No** ◯ **Yes** : ______________________________
Current Harm to Others Plan: ◯ **No** ◯ **Yes** : ______________________________
Current Harm to Others Intent: ◯ **No** ◯ **Yes** : ______________________________
Relevant History: ______________________________

Risk to others: ◯ **Not Apparent** ◯ **Low** ◯ **Medium** ◯ **High**

Risk of harm from others: ◯ **Yes** ◯ **No**

Comments: ______________________________

CURRENT RISK MANAGEMENT PLAN

◯ **Yes,** date of plan: ____________________

◯ **No,** preparation of plan will be completed on ____________________ By: ____________________

◯ **N/A** Please comment: ______________________________

Comments: ______________________________

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CONSENT

Consent to participate:

North Western Melbourne PHN (NWMPHN) and cohealth are required to collect and use information about you. This includes personal information, and information about the services you are receiving. This information is used by staff members involved in delivering services to you, and by staff at NWMPHN. This information is used and shared to ensure you get the right service for your needs, to monitor service delivery and performance, and evaluate and make improvements to services. If consent is withheld, service provision may be limited.

I/ parent/guardian consents to receive services and for the collection and use of information about me and the services I receive, as outlined above. ☐ **Yes** ☐ **No**

NWMPHN funded services are evaluated to ensure they are meeting the needs of consumers and our community. You may be contacted to participate in additional evaluation activities associated with your care. If contacted, you can choose whether you wish to take part or not.

Consent to collect and share information with other services:

I/ parent/guardian consents to the collection and sharing of all relevant information with other service providers relevant to assist my/my child's overall care. I understand that my information will not be shared if I do not consent. ☐ **Yes** ☐ **No**

If YES, please list all service providers you consent to being contacted by NWMPHN or cohealth and discussing your/your child's care (e.g. GP, Psychiatrist, CAT team, allied health professionals etc.).

	Name	Organisation	Contact details
Please Select			Phone: Fax:
Please Select			Phone: Fax:
Please Select			Phone: Fax:
Please Select			Phone: Fax:

Consent to share anonymized data with the Department of Health:

As the overall funder, the Department of Health is interested in anonymized data which will be used for evaluation purposes to improve mental health services in Australia. This anonymized data includes information about you, such as your gender, date of birth and types of services received, but **does not** include any information that could identify you (e.g. your name, address or Medicare number).

I/parent/guardian consents to NWMPHN and cohealth providing anonymized data about me and the services I receive to the Department of Health. I understand that my information will not be shared if I do not consent.

☐ **Yes** ☐ **No**

Consumer Signature:____**Date:**____/____/____

☐ Verbal Consent Provided by consumer **Referrer Signature:**____________________**Date:**____/____/____

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