Next Step Referral Form

Please note, we are not a crisis service, if crisis assistance is required, please call CATT on 02 6205 1065 or emergency on 000

REFERRAL DETAILS					
Referrer source:	☐ GP	☐ Psychiatrist	☐ Paediatrician		
Referrer Name:		**Practice Name:**			
Contact details:					
Referral Information:	☐ GP MHTP (required for GPs)	☐ Referral Letter (required for Psychiatrist and Paediatrician)			

NEXT STEP SERVICES & ELIGIBILITY (Please refer to Exclusion Criteria on **CHN website**)		
Severity	**Service and service details**	**Eligibility – must meet all of the following**
Mild to Moderate (some symptoms, mild effect on daily function)	☐ **Low Intensity psychological interventions** *Short term guided self-help in the form of low intensity CBT (LiCBT), 6 sessions, mainly phone based, delivered by a LiCBT Coach*	☐ 16 years + ☐ Live, work and/or study in the ACT
Moderate to Severe (moderate symptoms and significant impact on daily function)	**High Intensity psychological interventions** *Short term CBT, up to 18 sessions, face to face, delivered by a Mental Health Professional* ☐ Child (under 12 yrs) ☐ Youth (12- 25 yrs) ☐ Adult (26 years +)	☐ Live, work and/or study in the ACT ☐ Unable to access Medicare psychological services (Better Access) due to financial and or other constraints ☐ Currently not accessing other psychological interventions (excluding drug & alcohol or pain mgmt. services) ☐ Not better suited to a crisis, specialist or domestic violence service

PATIENT INFORMATION					
Full name:		**Preferred Name:**		**D.O.B:**	
Address:				**Postcode:**	
Contact No.:		**Voice Message?**	☐ Yes ☐ No, any precautions?_____		
Contact Information:	**Preferred Contact (e.g patient/carer):**_____ **Preferred Contact Time**: _____				
Email Address		**Gender:**	☐ Male ☐ Female ☐ Other_____		
Aboriginal and Torres Strait Islander Status:	☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither				
Country of Birth:		**Main Language Spoken:**		**Interpreter Required:**	☐ Yes ☐ No
Proficiency in English	☐ N/A (if main language is English) ☐ Very well ☐ Well ☐ Not well ☐ Not at all				
Marital status:	☐ Never Married ☐ Married (registered and de facto) ☐ Separated ☐ Divorced ☐ Widowed ☐ N/A				
Accommodation:	☐ Not homeless ☐ Sleeping rough or in non-conventional accommodation ☐ Short term/emergency Housing				
Employment:	☐ Employed Full time ☐ Employed Part time ☐ Unemployed ☐ Not in the labour force				
Income Source: (N/A for under 16yrs)	☐ Disability Support Pension ☐ Other pension/benefit ☐ Paid employment ☐ Compensation payments ☐ Other (e.g superannuation, investments etc) ☐ Nil income ☐ Not known				
Health Care Card:	☐ Yes ☐ No	**NDIS participant:**	☐ Yes ☐ No		

CARER/GUARDIAN INFORMATION (if applicable)					
Name:		**Relationship:**		**Contact Details:**	

Referral Requirements – ***Please complete all sections, or the referral may be returned for completion.***

Mental Health Diagnoses (if applicable)	**K10+ Score** (16yrs +)

Principal Focus Of Treatment : Please tick all that apply

☐ Anxiety symptoms, specify _____ ☐ Depression symptoms ☐ Stress related ☐ Adjustment ☐ Sleep disturbance
☐ Post-traumatic stress ☐ Suicidal Ideation ☐ Other difficulties of childhood and adolescence ☐ Other _____

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Co-morbid Issues : Please tick all that apply

☐ Drug and/or Alcohol ☐ Personality Features ☐ Physical Illness/Chronic Pain ☐ Family Violence

☐ Psychosocial stressors, specify_____ ☐ Developmental disorders, specify_____ ☐ Other _____

Current services involved in care: Please tick all that apply

☐ Adult Community Mental Health Team ☐ CAMHS ☐ Other Community Services, specify_____

☐ Drug and alcohol service ☐ Pain Mgmt Services ☐ Psychiatrist ☐ Other _____

Current Medications: Please tick all that apply

☐ Antidepressants ☐ Antipsychotics ☐ Anxiolytics ☐ Hypnotics and sedatives ☐ Psychostimulants and nootropics

Any Additional Information for the referral (optional)

CONSENT – Patient or Parent/Guardian for a Child

Patient has been informed of the Mental Health services that ACT PHN provides. Patient understands the information provided in this referral is required to determine their eligibility for services. Patient consents to their de-identified information to be used for statistical purposes for ACT PHN and Department of Health	☐ Patient Consents
If your patient is linked in with ACT Community Mental Health Teams (Adult/CAMHS), do they consent to their information being shared for Triage purposes?	☐ Yes ☐ No
Referrer's Signature:	***Date:*** _____ /_____ /_____

Please fax this form with required documents to 02 6100 9961.
Please call 6287 8090 or email nextstep@chnact.org.au if you require assistance or further information.