nextstep Referral/Review Form

Please complete this form together with a copy of the GP Mental Health Treatment Plan and fax to the Confidential Fax line 6100 9961.

Select the item this form refers to:	☐ **REFERRAL** ☐ **REVIEW**				
REFERRER DETAILS	☐ GP ☐ Psychiatrist ☐ Paediatrician ☐ Other (please specify):				
Referrers Full Name:				**Contact No:**	
Practice/Organisation name:		**Postcode:**		**Fax:**	
PATIENT INFORMATION					
Full name:		**DOB:**	____/_____/_____		
Address:				**Postcode:**	
Contact No.:		**Gender:**	☐ Male ☐ Female ☐ Other		
Aboriginal and Torres Strait Islander Status:	☐ Aboriginal but not Torres Strait Islander origin ☐ Torres Strait Islander but not Aboriginal origin ☐ Both Aboriginal and Torres Strait Islander origin ☐ Neither Aboriginal/Torres Strait Islander origin				
Country of Birth:		**Main Language Spoken at Home:**		**Interpreter Required:**	☐ Yes ☐ No
English level:	☐ N/A (if speak English only or under 5 years of age) ☐ Very well ☐ Well ☐ Not well ☐ Not at all				
Marital status:	☐ Never Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Married (registered and de facto)				
Accommodation:	☐ Sleeping rough or in non-conventional accommodation ☐ Short term/emergency Housing ☐ Not homeless				
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		

nextstep Referral Requirements – *Please complete all sections, or the referral may be returned for completion.*	
GP MHTP completed	☐ GP MHTP ☐ Referral Letter attached ☐ Additional Information attached
Outcome Tool	K 10+ score_____ (N/A for children under 12 years)

Primary Diagnosis : Please tick all that apply

☐ Alcohol and drug use disorder, specify _____	☐ Adjustment disorder	☐ Conduct disorder
☐ Anxiety disorders, specify _____	☐ Depression	☐ Eating disorder
☐ Attention deficit hyperactivity disorder (ADHD)	☐ Oppositional defiant disorder	☐ Personality disorder
☐ Other disorder of childhood and adolescence	☐ Pervasive developmental disorder	☐ Stress related
☐ Psychotic disorders, specify _____	☐ Suicidal Ideation	☐ Unexplained somatic disorders
☐ Post-traumatic stress disorder	☐ Other (please specify)_____	

Principal Focus of Treatment :

☐ Low Intensity psychological intervention (mild to moderate presentations)
☐ High Intensity psychological intervention (moderate to severe presentations)

Preferred High Intensity Clinician: (optional) ☐ Jane Flanagan ☐ Lisa Plaza ☐ Rebecca Fitzpatrick ☐ Veronica O'Connell ☐ Sue-Ann Polden

Receiving Psychotropic Medication:

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

Does your patient consent to being referred to Mental Health Services for Psychological Services?		☐ Yes ☐ No	
Referrer's Signature:		***Date:***	_____/_____/_____

Please fax completed form with the completed GP Mental Health Treatment plan to 6100 9961. Call 6287 8090 or email nextstep@chnact.org.au if you require assistance or further information.