Next Step Referral Form

Please note, we are not a crisis service, if crisis assistance is required, please call Access Mental Health 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**)			
Please consider for;		**Eligibility – must meet all of the following**	
CBT based psychological interventions: *6- 18 targeted individual sessions with a CBT trained professional* ☐ **Adult Individual CBT (26 years +)** ☐ **Youth Individual CBT (12- 25 yrs) *please note for mild to moderate presentations for 12-16-years please refer to Headspace** **Child (under 12 yrs)** ☐ Cool Little Kids or Cool Kids Group evidence based 10-week group to build strategies to manage anxiety and associated behaviours. ☐ Individual psychological intervention 6- 16 sessions.		☐ 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 ☐ Mental Health Treatment Plan Attached	
PATIENT INFORMATION			
Full name:		**Preferred Name:**	**D.O.B:** _____/____/_____
Address:		**Postcode:**	
Contact No.:		**Voice Message?**	☐ Yes ☐ No
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		
Accommodation:	☐ Not homeless ☐ Sleeping rough or in non-conventional accommodation ☐ Short term/emergency Housing		
Employment:	☐ Full time ☐ 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 INFORMATION			
Mental Health diagnosis		**K10+ Score** (16yrs +)	
CURRENT MEDICATIONS			
☐ Antidepressants ☐ Antipsychotics ☐ Anxiolytics ☐ Hypnotics and sedatives ☐ Psychostimulants and nootropics			

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CURRENT SERVICES Please tick all that apply		
☐ Adult Community Mental Health Team	☐ CAMHS	☐ Psychiatrist
☐ Drug and alcohol service	☐ Pain Mgmt. Services	☐ Other _____

PRINCIPLE FOCUS OF TREATMENT
☐ Depressive Symptoms (please state)
☐ Anxiety Symptoms including OCD and PTSD (please state)

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
Under 12's Parent/Carer willing to participate in sessions (group and/or individual) to support child towards best outcomes	☐ Parent/Carer agrees
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 ensure the referral is complete as it may be returned if information is missing

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.