GP Referral Form

headspace Armadale is a free, youth-friendly and confidential service available to young people aged 12 – 25 years, in the south east metropolitan region of Perth. **headspace** Armadale brings together a range of co-located community-based and government agencies, to provide a holistic service as a "one-stop-shop" for young people. We offer information, intake, assessment and referral.

The services available at **headspace** Armadale include:

- Youth Friendly General Practitioner/s
- Youth Support Workers
- Sexual health clinic
- Drug and alcohol outreach worker
- MBS & ATAPS Psychological services
- Vocational support worker

How to refer

Professional Referral

- Referrals accepted from GP's, Allied Health Professionals, community-based agencies and educational institutions
- Where available, GP's should include a copy of the client's Mental Health Treatment Plan

Client Details

Date of Referral	**DOB** / / **Age**	
Name	**Gender**	
Address		
Email	**Mobile**	**Home Phone**
Medicare No.	**Reference No.**	**Expiry Date:**
Are there any safety concerns when contacting the patient by phone/mail?		

Consent to contact young person via: (e.g. confirm appointments etc.)

Mobile: ☐ Yes ☐ No **Text:** ☐ Yes ☐ No **Voicemail:** ☐ Yes ☐ No

Email: ☐ Yes ☐ No **Mail:** ☐ Yes ☐ No **At home:** ☐ Yes ☐ No

Preferred method of contact ***(this can change and other arrangements can be made):***

Language spoken at home?
Ability to speak English? ☐ Very well ☐ Well ☐ Not well ☐ Not at all **Preferred Language**
What is the client's cultural background? ☐ Aboriginal ☐ TSI ☐ Other ☐ Unknown
Who does the young person live with?
Education/employment status?
Is the client aware and consented to the referral and wanting treatment?

Next of Kin (MUST be completed if client is under 16 unless mature minor process followed)

Next of Kin name ..... **Mobile number** .....

Relationship to client ..... **Home number** .....

Is the young person's parent/guardian aware that this referral has been made? ☐ Yes ☐ No

Reason for Referral

Presenting Issues *(please include here any information which may be useful as background information to assist with the referral e.g. mental health, drug and alcohol, vocational/educational, physical health, including past/current risk assessments)*

☐ Mental health ☐ Sexual health ☐ Alcohol/drugs

☐ Situational ☐ Physical health ☐ Social support ☐ Family support

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☐ Eating ☐ Vocational/education ☐ Friendships ☐ Relationships/sexuality
☐ Home/environment

Mental health diagnosis (if relevant) *(Please attach copy of current Mental Health Treatment Plan if available)*

Duration of presenting problem

Recent Stressors *Are there any legal proceedings pending? (please note headspace is unable to provide opinion re: legal matters or supporting documents)*

Client History *(Relevant biological, psychological, physical and social history, including family history)*

Relevant medications:

Risk to self or others *(include self-harm/suicide attempts, violence, threats of violence)*
PLEASE NOTE: headspace does not provide crisis or acute care, if in crisis please refer to the closest Emergency Department or call the Mental Health Emergency Response Line (MHERL) on 1300 555 788

Other Care Providers Involved (Previous/Current) *(is the young person linked in with any other services? For example CAMHS)*

Admissions to hospital related to mental health? **If so, how many?**

Referrer Details

Name **Relationship to the client**

Address

Organisation **Contact Number**

Client's GP (if not the referrer):

Name **Practice**

Address

Consent Details

Please indicate who is consenting to collection, use and disclosure of personal health information:

☐ Adult client ☐ Adolescent client (aged 16 or over) ☐ Parent/guardian ☐ Mature minor

All information will be treated confidentially and will not be used for any other purposes that what is stated in the full consent form (signed during the first appointment). I am aware that this referral is being made. I understand I can withdraw from this service at any time. The client has been made aware of this referral.

Client name	Client signature	Date
Parent/guardian name	Parent/guardian signature	Date

FAX THIS REFERRAL TO HEADSPACE ARMADALE ON 9393 0399 or email to referrals@headspacearmadale.com.au

Please note that headspace Armadale does not provide crisis or acute care mental health services.
For mental health emergencies contact the Mental Health Emergency Response Line on 1300 555 788.

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GP Referral Form

Please use this MHCP or attach your own

GP MENTAL HEALTH TREATMENT PLAN (MBS ITEM NUMBER 2715/2717 or 2700/2701)			
Patient's Name		**Date of Birth**	
Address		**Phone**	
GP Name/Practice **Provider Number**			
PRESENTING ISSUE(S) What are the patient's current mental health issues			
PATIENT HISTORY Relevant biological, psychological, physical social history including family history of mental disorders and any relevant substance abuse			
MEDICATIONS (attach information if required)	**Is the patient receiving psychotropic medication?** ☐ **Yes** ☐ **No** **If yes, *please specify below*** ☐ Benzodiazepines & Anxiolytics ---------- ☐ Antidepressants ---------- ☐ Phenothiazines & Tranquilisers ---------- ☐ Mood Stabilisers ----------		
PREVIOUS MENTAL HEALTH CARE	**Has the patient ever received specialist mental health care before (public/private, medical/allied health)?** ☐ No ☐ Yes **If yes, *please specify below***		
OTHER RELEVANT INFORMATION	*Are there any legal proceedings pending? (please note InFocus is unable to provide opinion re: legal matters or supporting documents)* ☐ No ☐ Yes **If yes, *please specify*** <u>*For perinatal referrals only:*</u> Due birth date: Actual birth date:		
RESULTS OF MENTAL STATE EXAMINATION Record after patient has been examined	**Appearance and Behaviour** ☐ Normal ☐ Other	**Mood** (Depressed/Labile) ☐ Normal ☐ Other	
	Thinking (Content/Rate/Disturbance) ☐ Normal ☐ Other	**Affect** (Flat/Blunted) ☐ Normal ☐ Other	
	Perception (Hallucinations etc.) ☐ Normal ☐ Other	**Sleep** (Initial Insomnia/Early Morning Wakening) ☐ Normal ☐ Other	
	Cognition (Level of Consciousness/Delirium) ☐ Normal ☐ Other	**Appetite** (Disturbed Eating Patterns) ☐ Normal ☐ Other	

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GP MENTAL HEALTH TREATMENT PLAN (MBS ITEM NUMBER 2715/2717 or 2700/2701)

DIAGNOSIS

ICD-10 Primary care diagnostic categories

☐ F1 – Alcohol & Drug Use ☐ F2 – Psychotic disorders ☐ F3 – Depression ☐ F4 – Anxiety

☐ F5 – Unexplained somatic complaints ☐ Unknown ☐ Other

PATIENT NEEDS/MAIN ISSUES

GOALS Record the mental health goals agreed to by the patient and GP and any actions the patient will need to take

TREATMENTS
Treatments, actions and support services to achieve patient goals

Referred for which strategies:

☐ Diagnostic Assessment
☐ Psycho-education
☐ Interpersonal therapy
☐ Narrative Therapy
☐ Family Therapy (perinatal referrals only)
☐ Other *(please specify)*

Cognitive-behavioural therapy (CBT):

☐ Behavioural Interventions
☐ Cognitive Interventions
☐ Relaxation Strategies
☐ Skills training
☐ Other CBT interventions

REFERRALS

CRISIS/RELAPSE
If required, note the arrangements for crisis intervention and/or relapse prevention

COMPLETING THE PLAN

On completion of the plan, the GP is to record that s/he has discussed with the patient:

☐ The assessment;
☐ All aspects of the plan, including referrals to other providers
☐ Agreed date for review
☐ Offered a copy of the plan to the patient and/or their carer (if agreed by patient)

DATE MENTAL HEALTH TREATMENT PLAN COMPLETED

REVIEW DATE (initial review 4 weeks to 6 months after completion of plan)

	Attention/Concentration ☐ Normal ☐ Other	**Motivation/Energy** ☐ Normal ☐ Other
	Memory (Short and Long Term) ☐ Normal ☐ Other	**Judgement** (Ability to make rational decisions) ☐ Normal ☐ Other
	Insight ☐ Normal ☐ Other	**Anxiety Symptoms** (Physical and Emotional) ☐ Normal ☐ Other
	Orientation (Time/Place/Person) ☐ Normal ☐ Other	**Speech** (Volume/Rate/Content) ☐ Normal ☐ Other
RISKS AND CO-MORBIDITIES	Suicidal Ideation ☐ **Yes** ☐ **No**	Suicidal Intent ☐ **Yes** ☐ **No**
	Current Plan ☐ **Yes** ☐ **No**	Risk to Others ☐ **Yes** ☐ **No**
OUTCOME TOOL USED E.g. K10, DASS-21	**RESULTS** *(please attach with referral)*	

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