Integrated Recovery Services Referral form

Only complete **parts 2 - 4** if GP Mental Health Treatment Plan is not attached

Part 1 - Personal Information

Name:	Date of birth:
Address:	Postcode:
Email:	Gender: ☐ Male ☐ Female ☐ Other
Home phone:	Mobile:

Preferred method of contact		**Details** *(eg morning / afternoon)*
☐ Mobile	☐ SMS	
☐ Home phone	☐ Face to face	
☐ Email		

Eligibility for service

Diagnosed **Serious and Enduring** Mental Illness

Diagnosis:

_____

_____

Date Diagnosed:

_____

Treating GP / Doctor details

Name**:** _____

Practice: _____

Address: _____

Suburb: _____ Postcode: _____

Ph: _____ Fax: _____

Part 2 – Referral Information

(only complete if GP Mental Health Treatment Plan is not attached)

Reason for referral (briefly explain)

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Current symptoms

- ☐ Hallucinations
- ☐ Delusions
- ☐ Thought disorder
- ☐ Bizarre / psychotic behavior (please describe)

_____

_____

- ☐ Anxiety
- ☐ Sleep disturbance
- ☐ Depressed mood

- ☐ Phobias / fears
- ☐ Aggression / disruptive behavior
- ☐ Mood swings
- ☐ Other (please describe)

_____

_____

Relevant medical and social history

Health and mental health history, family relationships, trauma history, education and employment history etc.

Current prescribed treatment

Mental Health including medication, psychological therapy etc.

Health including smoking cessation, weight loss, metabolic syndrome management etc.

Other

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Current therapies, supports and services

Participant's areas of interest for Complex Care Services

- ☐ Assistance with improving adherence to treatment
- ☐ Medication management
- ☐ Recovery planning and goal setting
- ☐ Recovery coaching
- ☐ Relapse planning and prevention
- ☐ Skill building in self-management
- ☐ Coping with stress
- ☐ Health change
- ☐ Building and maintaining natural and social supports
- ☐ Other (please specify)

_____

Potential or identified barriers to engagement

Risks including to self or other of harm or exploitation (attach risk assessment if available)

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Specific worker requirements (Please outline preferences, e.g. gender)

Part 3 – Consumer consent
(only complete if GP Mental Health Treatment Plan is not attached)

I confirm that I have discussed the complex mental health program with the consumer and:	Please confirm that the consumer is agreeable to DIRECT contact by a member of the GPH Access team to progress this referral:
☐ They have provided **WRITTEN** consent to make this referral and this is attached ☐ They have given me **VERBAL** consent to make this referral ☐ The consumer has **NOT** given consent for this referral	**Yes (specify preferred method)** ☐ Phone ☐ Email ☐ Other (specify) ☐ **No - contact referrer only**

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Part 4 – Referrer Information (only complete if GP Mental Health Treatment Plan is not attached)	
Referrer Name:	Referrer Address:
Referrer Phone:	Referrer Email:
Referrer date:	Comments:

Please attach GP Mental Health Treatment Plan and any relevant Pathology results (within 3 months)

Grand Pacific Health will contact you to discuss this referral further or can be contacted on:

Ph: 1800 228 987

Fax: 02 42266489

Thank you for referring to the Integrated Mental Health Recovery Service Team.