Mental Health Nurse Program Referral Form

Date of Referral:

Referrer Details			
Name:		GP Practice:	
Address:			
Suburb:			Postcode:
Phone:	Mobile:	Fax:	
Email:			

Patient Details		
Name:		
Address:		
Suburb:		Postcode:
Phone:	Mobile:	
Email:		
Date of Birth:	Age:	

GP Treatment Plan attached ☐	Date of Plan:

Version 2.0 - November 2019

Reason for referral (eligibility criteria)	
☐	A diagnosed mental health disorder (according to criteria defined in the *Diagnostic and Statistical Manual of Mental health Disorders – IV Ed of the World Health Organisation/ Diagnostic and Management Guidelines for Mental Health Disorders in Primary Care: ICD-10 Chapter V Primary Care version*)
☐	The patient has been previously hospitalised for treatment for the mental health disorder, or are at risk of hospitalisation
☐	The patient is expected to need long term management of the mental health disorder
☐	The patient provides consent to services from a mental health nurse
☐	A primary care based GP or psychiatrist maintains responsibility for the patient's management
☐	The mental health disorder significantly impacts the person's social, personal and/or occupational function

Diagnosis:	Phone:
Diagnosed by:	Mobile:
Email:	
Address:	
Suburb:	Postcode:

Risk Factors			
☐	Recent suicide attempt	☐	Homelessness/unstable accommodation
☐	Deliberate self harming	☐	Risk of exploitation
☐	Substance abuse	☐	Care of children
☐	Poor self-care	☐	Poor supports
Risk assessment attached Yes / No		Date:	
Mental Health Issues			
☐	Sleep	☐	Hallucinations
☐	Appetite / food intake	☐	Delusions
☐	Depressed mood	☐	Other
☐	Elevated mood		

Mental Health Issues: Further details

Current Medications:

Other services involved			
☐	ACMHS	☐	Private Psychiatrist
☐	Private Psychology	☐	Other:

☐	As the referring medical practitioner I confirm: I am satisfied that the patient understands that by referring them to the MHNP their personal information will be provided to the MHNP provider, that the provider will make contact with them directly and that they have provided informed consent for this referral
Signed:	
Print name:	
Date:	

Please send referrals to:

Richmond Fellowship Tasmania
F: 6228 3300
E: referrals@rftas.org.au