

Referral Form – Mental Health Nurse Program

Date of referral:

| Referrer details | Patient Details |
|------------------|-----------------|
| Name | Name |
| GP Practice | Address |
| Address | Phone |
| Phone | Mobile |
| Mobile | Email |
| Fax | Date of Birth |
| Email | Age: |

Eligibility

| | |
|---|--|
| GP Treatment plan attached <input type="checkbox"/> | Date of Plan: _____ |
| Reason for referral (eligibility criteria) | |
| <input type="checkbox"/> A diagnosed mental health disorder (according to criteria defined in the <i>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</i>) | <input type="checkbox"/> The patient is expected to need long term management of the mental health disorder |
| <input type="checkbox"/> The patient has been previously hospitalised for treatment for the mental health disorder, or are at risk of hospitalisation | <input type="checkbox"/> The patient provides consent to services from a mental health nurse |
| | <input type="checkbox"/> A primary care based GP or psychiatrist maintains responsibility for the patient’s management |
| | <input type="checkbox"/> The mental health disorder significantly impacts the person’s social, personal and/or occupational function |

Diagnosis

| | |
|---------------|---------|
| Diagnosis: | Phone: |
| Diagnosed by: | Mobile: |
| Address: | Email: |

Risk Factors

| | |
|--|--|
| <input type="checkbox"/> Recent suicide attempt | <input type="checkbox"/> Homelessness / unstable accommodation |
| <input type="checkbox"/> Deliberate self harming | <input type="checkbox"/> Risk of exploitation |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Care of children |
| <input type="checkbox"/> Poor self-care | <input type="checkbox"/> Poor Supports |
| Risk assessment attached | Y / N |
| Date | _____ |

Mental Health Issues

- | | |
|---|---|
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Appetite / food intake | <input type="checkbox"/> Delusions |
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> other |
| <input type="checkbox"/> Elevated mood | <input type="checkbox"/> |

Further details:

Current Medications:

Other services involved

- | | |
|---|---|
| <input type="checkbox"/> ACMHS | <input type="checkbox"/> Private Psychiatrist |
| <input type="checkbox"/> Private Psychology | <input type="checkbox"/> 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