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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 ☐ **Date of Plan:_______________**

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

More details:

Diagnosis

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

Risk Factors

☐ Recent suicide attempt	☐ Homelessness / unstable accommodation
☐ Deliberate self harming	☐ Risk of exploitation

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- ☐ Substance Abuse
- ☐ Poor self-care
- ☐ Care of children
- ☐ Poor Supports

Risk assessment attached Y / N Date ____________________

Mental Health Issues

- ☐ Sleep
- ☐ Appetite / food intake
- ☐ Depressed mood
- ☐ Elevated mood
- ☐ Hallucinations
- ☐ Delusions
- ☐ other
- ☐

Further details:

Current Medications:

Other services involved

- ☐ ACMHS
- ☐ Private Psychology
- ☐ Private Psychiatrist
- ☐ 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@richmondtas.com.au