

# PHN mental health intake form

for stepped care services

This form is for:

- Hospital and health staff
- Allied health professionals
- Clinicians within community organisations

To send **completed referral form**, or for help completing the form, please contact the PHN Intake Team via:

Phone  
  
1300 747 724

Fax (preferred)  
  
1300 787 494

Email (see below)  
  
[mentalhealthintake@ourphn.org.au](mailto:mentalhealthintake@ourphn.org.au)

*Client privacy is our concern. Please keep in mind that communications via email are not secure. Although it is unlikely, there is a possibility that information included in an email can be intercepted and read by other parties. By emailing us, you agree that the client consents and accepts this risk.*

## IMPORTANT REFERRAL INFORMATION

Fields with \* denote a mandatory field. Referral will NOT be accepted if field is left blank.

Stepped Care Intake is NOT an acute service. Clients with significant risk should be referred to the local Acute Care Team by calling 1300 MH CALL (1300 642 255).

Referrer Details				
Referrer name*			Date of referral*	
Referrer position/profession*			Referrer phone*	
Referrer email			Referrer fax	
Referrer address*				
Client Consent and Basic Client Demographics				
<b>Has consent been given for referral?*</b> <input type="checkbox"/> Client consent <input type="checkbox"/> Guardian consent <input type="checkbox"/> No (do not proceed)				
<b>If under 18, but mature minor, can referral be discussed with guardian?*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (>18)				
<b>Is it OK for the PHN to contact the client/guardian, if required?</b> <input type="checkbox"/> Call <input type="checkbox"/> SMS <input type="checkbox"/> Do not contact				
Client name*				
DOB*			Gender*	
Indigenous identity (tick relevant)*	Torres Strait Islander <input type="checkbox"/>	Aboriginal <input type="checkbox"/>		
Country of birth*		Preferred Language	Interpreter required	
Co-morbidities / medical history (if known)				
Substance use (if applicable)				
Client GP Details (if known)				
GP name			GP phone number	
GP clinic name			GP fax	

## Other Client Demographics

NB – these fields are required to determine eligibility for psychological therapies

<b>GP MH Treatment Plan*</b>	<input type="checkbox"/> Completed	<input type="checkbox"/> Not completed	<input type="checkbox"/> Unknown
<b>Homelessness*</b>	<input type="checkbox"/> Sleeping rough	<input type="checkbox"/> Emergency accommodation	<input type="checkbox"/> Not homeless
<b>Employment</b>	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Employed part-time	<input type="checkbox"/> Employed full-time
<b>Financial disadvantage*</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes - if yes, provide concession card no.	
<b>Source of income*</b>	<input type="checkbox"/> Paid employment	<input type="checkbox"/> Disability Support Pension	<input type="checkbox"/> Other
	<input type="checkbox"/> Nil income	<input type="checkbox"/> Other Pension (eg NewStart)	<input type="checkbox"/> Unknown
<b>NDIS and support coordination*</b>	<input type="checkbox"/> NDIS with support coordination	<input type="checkbox"/> NDIS without support coordination	<input type="checkbox"/> No NDIS
<b>Rural or remote (MM4-7)*</b> (See <a href="#">search tool</a> to check)	<input type="checkbox"/> Rural or remote	<input type="checkbox"/> Not rural or remote	<input type="checkbox"/> Unknown
<b>CALD*</b>	<input type="checkbox"/> Yes CALD	<input type="checkbox"/> No CALD	<input type="checkbox"/> Unknown
<b>LGBTIQ+*</b>	<input type="checkbox"/> Yes LGBTIQ+	<input type="checkbox"/> No LGBTIQ+	<input type="checkbox"/> Unknown
<b>Perinatal depression</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<b>Domestic/family violence</b>	<input type="checkbox"/> Affected by DFV	<input type="checkbox"/> Perpetrator DMV	<input type="checkbox"/> No DMV
<b>Private health insurance</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

## Client Contact Details

Address			
	Suburb*		Postcode
Client mobile*		Client home phone	
Guardian name and contact (if applicable)			

## Referral Information

What support do you believe this person requires?\*

<input type="checkbox"/>	Low intensity mental health support (e.g. 6 telephone coaching sessions)
<input type="checkbox"/>	Psychological therapy (e.g. 6 face-to-face psychology appointments)
<input type="checkbox"/>	Care coordination for severe and complex mental health conditions
<input type="checkbox"/>	Intensive coordination following a suicide attempt – The Way Back Support Service ( <b>referrals from hospital only</b> )
<input type="checkbox"/>	Aboriginal or Torres Strait Islander peoples-specific mental health support

Reason for referral\*

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## Risk Information

The below section is based on the [Initial Assessment and Referral national guidance](#).

It is a **provisional assessment only** and aims to inform the most appropriate response and/or referral.

**Suicidality\***

- 0 = No risk
- 1 = Low risk (e.g., no current suicidal ideation but may have experienced ideation in the past)
- 2 = Moderate risk (e.g., current suicidal ideation, without plan or intent)
- 3 = High risk (e.g., current suicidal ideation with intent; history of attempts; some protective factors)
- 4 = Extreme risk (e.g., current suicidal intention with plan and means to carry out)

**Self-harm (non-suicidal self-injurious behaviour)\***

- 0 = No risk
- 1 = Low risk (e.g., occasional self-harming behaviours in recent past, not requiring surgical treatment)
- 2 = Moderate risk (e.g., frequent self-harming behaviours in recent past, not requiring surgical treatment)
- 3 = High risk (e.g., frequent self-harming behaviours in recent past requiring surgical treatment)
- 4 = Extreme risk (e.g., long history of repeated, life-threatening self-harm or dangerous behaviour)

**Risk of harm to self and others\***

- 0 = No risk
- 1 = Low risk (e.g., past behaviours that posed a risk to others)
- 2 = Moderate risk (e.g., recent behaviours that pose non-life-threatening risk to self or other)
- 3 = High risk (e.g., recent life-threatening risk to self or others)
- 4 = Extreme risk (e.g., recent behaviour that poses an imminent danger to self or others)

**If moderate risk or greater in any category, please add comments\*****Has a safety plan been completed?**

- Yes – if yes, attach if possible  No

**Has the client ever been hospitalised due to their mental health?**

- Yes – if yes, date of most recent admission:  No

**Assessments**

Please indicate the score of any assessments undertaken

	Kessler Psychological Distress Scale (K10+)
	Kessler 5 Psychological Distress Scale (K5 - for Aboriginal and Torres Strait Islander people)
	Suicidal Ideation Attributes Scale (SIDAS)
	Depression, Anxiety and Stress Scale (DASS-21)
	Other – please specify

**GP Mental Health Treatment Plan (MHTP)**

Where possible, please attach GP MHTP. A plan is required for a referral for **psychological therapies (Stream 3)** and **adult clinical care coordination (Stream 4)**. It is recommended for **child and youth care coordination (Stream 2)**.

If MHTP does not accompany referral, the PHN will accept a 'provisional' referral, providing that a MHTP is obtained by the client in a reasonable time after the first session.