|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Referral:** |  | | **Reason for referral: *See descriptors on page 2)***   Well-being Support Service   \*Targeted Psychological Support Service (for people 12+ years)   Targeted Psychological Support Service (for children under 12 years)   \*Intensive Support Service (formerly Mental Health Nurse Service)   Suicide Support Services  \*A Mental Health Treatment Plan is preferred to access these services. |
| **REFERRER DETAILS:**  **Referrer Relationship to client:**  **Referrer Name:**  **Referrer Organisation:**  **Address:**  **Postcode:**  **Telephone:**  **Fax:**  **Email:** |  | |
| **CLIENT DETAILS:**  **Your Title: Your First Name: Your Last Name: Preferred Name:**    **DOB: Marital Status: Country of Birth:** | | | |
| **Client Phone no**. (H) (M) | | | **Parent /Guardian name**: (if child under age 16) |
| **Your Address (please include postcode):**  **Your Email: Preferred method of contact:** Phone/mobileEmail | | | |
| **Your Gender**:  Male  Female  Other Do you identify as LGBTIQA  Yes  **Do you identify as:**  Aboriginal  Torres Strait Islander  Both Aboriginal & Torres Strait Islander   Non Indigenous  **Language spoken at home:** English only Other specify: \_\_\_\_\_\_\_\_\_\_\_\_  **English Level:** Very well  Well Not Well  Not at all  **Interpreter required:**  Yes  No **If yes, specify language** **required:** | | | |
| * **Do you hold a Health Care Card or similar?**   If Yes, please write HCC Number and expiry date:   * **Are you a National Disability Support Scheme (NDIS) participant?** | | |  Yes  No  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Yes  No |
| Have you been **homeless in the previous 4 weeks?** | | **Employment participation:** | **Are you at risk of suicide**? |
|  Sleeping rough   Short term/emergency accommodation   Not homeless | |  Full Time   Part-Time  Not in the labour force | Thoughts  Yes No  Intent  Yes No  Plan  Yes No  Previous attempt  Yes No |
| **Principal Diagnosis (using DSM-IV)** – *Please tick all that apply* | | | |
|  Anxiety Disorders  Mood Disorders  Substance use disorders  Psychotic disorder   Disorders with onset usually occurring in childhood and adolescence  Other mental disorder   No formal diagnosis | | | |
| **K10** Score**: Other Measure** (specify): *(score)* | | | |
| **Current Medication** – *Please tick all that apply* | | | |
|  Anxiolytics  Antidepressants  Antipsychotics  Hypnotics and Sedatives  Psychostimulants & nootropics   Mood stabilisers | | | |
| **Name of preferred provider or preferred gender of provider *(optional):***  *NB: provider must be a registered with the NORTH WESTERN MELBOURNE PRIMARY HEALTH NETWORK (NWMPHN) CAREinMIND services* | | | |
| **Client Consent: Sharing Information**   ***Yes, I agree to be referred to the CAREinMIND service overseen by NWMPHN.***  ***I give consent for my referrer / my GP/ paediatrician/ psychiatrist to share my personal details, assessments and mental health treatment plan with my CAREinMIND provider and others involved in my/our care, and the Commonwealth Department of Health for service quality and evaluation purposes.***  ***Client signature:…………………………………………………………. Date: ………………………………………….***  **Client Consent: Evaluation**  ***Yes I consent to being contacted by NWMPHN to invite me to participate in the evaluation of CAREinMIND services. I agree that my contact details may be disclosed to the contracted evaluation provider for that purpose.***  **Client** **signature: ………………………………………………………… *Date:* …………………………………………..** | | | |
| **Referrer/GP Consent:**  ***Yes, I have discussed this referral with my client***  **Referrer/ GP Signature:……………………………………………….** **Date:…………………………………………….** | | | |

**GLOSSARY: CAREinMIND™ Mental Health Services**

***CAREinMIND™ prioritises referrals for individuals who reside in the NWMPHN catchment. Similarly, referrals may be prioritised for General Practitioners and other referrers who practice in the catchment.***

* **CAREinMIND™ Wellbeing Support Service** Phone or web-based support 24 hours per day. Available to all ages. Telephone contact **1300 096 269**
* **CAREinMIND™ Targeted Psychological Support Service** – (formerly known as ATAPS). Time limited face-to-face counselling located across the north west Melbourne region. Available to all ages.
* **CAREinMIND™ Intensive Support Service** – (formerly known as the Mental Health Nurse Service) - intensive supported intervention and clinical care coordination for individuals with severe and complex mental health diagnoses, located across the north-west Melbourne region. Available to individuals aged 16+ years. Delivered by **credentialed mental health nurses only**.
* **CAREinMIND™ Suicide Support Service** – time limited face-to-face intervention for those with episodic suicidal thoughts and self-harm located across the north-west Melbourne region. Available to all ages. *NOTE: A mental health diagnosis does not need to be indicated.*
* **CAREinMIND™ Youth Intensive Support Service** – intensive supported intervention for young people aged 12 to 25 years with significant and complex mental ill health, located across the north-west Melbourne region.

***Please visit:*** <https://nwmphn.org.au/health-systems-capacity-building/careinmind/> ***for more information.***