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| --- | --- | --- |
| **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 NoIntent  Yes NoPlan  Yes NoPrevious 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.***