

Connect to Wellbeing Referral Form



Servicing people in the North Queensland Primary Health Network catchment area, **Connect to Wellbeing** provides an intake, triage and assessment service that facilitates access to the service(s) that best support the mental health needs of the individual.

Please use this referral form to recommend a level of service.

The Connect to Wellbeing clinical triage and intake team will review the referral, your recommendation and the client; and will determine the right level of intervention, according to their individual wants and needs.

Date of referral _____ Services required for child (0-12) youth (12-25) adult (18+)

If the person has acute mental health needs, refer to the Acute Care Team or Child Youth Mental Health Service via 1300 64 2255

Please select your recommended service option for the person from the following:

Low Intensity Strategies

Psychological interventions for people with, or at risk of, **mild** mental illness.
(As available can be individual, group, face to face, telephone, web-based supports).

Psychological Therapies

For **low income / financially disadvantaged** people with a non-acute **moderate** mental health condition who would benefit from short-term goal focused psychological strategies.

Sessions required (select one of the below):

Sessions 1–6 (initial sessions), **OR**

Sessions 7–10 (following review post the initial 6 sessions, further sessions are recommended), **OR**

Sessions 11–16 Exceptional circumstances apply (a psychiatrist's written recommendation must accompany this request),

or/and **Group sessions** (Groups will be advertised as available)

Eligibility requires that (please tick):

A Mental Health Treatment Plan (MHTP) or Child Treatment Plan (CTP) is attached, **OR** Appendix A is completed **AND** The person has a Pension Card (aged or disability), Health Care Card or Low Income Health Care Card.

NB. Exceptions to the financial disadvantage requirement may apply – for more information, refer to www.connecttowellbeing.org.au

Psychological Therapies in Residential Aged Care Facilities (RACFs)

For people with a non-acute mental health condition who would benefit from short-term goal focused psychological strategies.

Eligibility requires that that the person meets the following criteria:

- The person resides in a Residential Aged Care Facility (RACF), **AND**
- The person has a mental illness or is at risk of developing a mental illness

Suicide Prevention Services – Low to Moderate Suicide Risk

NOT intended to support people who are at acute and immediate risk.

Where any of the following requirements are indicated, the person will be contacted **within 24hrs** (business days) of the date of referral and offered an appointment **within 72hrs**.

Sessions required (select one of the below):

Sessions 1–12 (initial sessions)

Please select at least one of the options below below if the initial 12 sessions are required:

After a suicide attempt or self-harm incident, the person has either been discharged from hospital into the care of a GP, or has been released into the care of a GP from an accident and emergency department.

The person has presented to a GP after an incident of self-harm.

The person has expressed recent suicidal ideation to their GP.

Sessions 13–18 (following review by GP within the 6–12 session window, further sessions are recommended).

Telehealth Specialist Services – specialist video consultations under Medicare

The provision of a consultation via video conferencing by a consultant psychiatrist.

NB. The person must have access to a computer or tablet, with a webcam and speakers or headphones.

Preferred location for the consultation (select one of the below):

GP practice (the GP or another health professional may be at the patient-end of the consultation to provide clinical services where clinically appropriate).

Client/patient home.

Other (please describe): _____

Additional requirements (tick if appropriate):

The patient/client is experiencing financial difficulty (fees are waived where this is indicated).

The patient/client understands they will be asked for credit card details and that a fee will be charged if an appointment that has been arranged is cancelled.

National Psychosocial Support Measure (NPSM)

Psychosocial support (for up to 12 months) for people with a severe episodic mental illness resulting in a reduced functional capacity.

Eligibility requires that the person meets the following criteria:

- Has a severe episodic mental illness resulting in reduced functional capacity.
- Is **not** currently a client of public mental health services (QLD health), the NDIS or any other government-funded Mental health support programs (such as CoS, NPST, IRSP, GRSP).
- Would benefit from less intensive, non-clinical, community-based psychosocial support.
- Would benefit from peer connections or group support.
- Is best supported in primary health care and is engaged with the primary health system (e.g. GP).

Mental Health Integrated Complex Care (MHICC)

Provides longer term (up to 2 years) clinical support and treatment for individuals with severe mental illness with complex needs.

Eligibility requires that the person meets the following criteria:

- Has a severe episodic mental illness resulting in reduced functional capacity.
- Consents to support/treatment from a Mental Health Nurse.
- Is **not** a current client of public mental health services and is not receiving case management through Queensland Health.
- Has a current Mental Health Treatment Plan (MHTP) that identifies at least two or more aspects of their life as significantly impacted by mental illness (e.g. relationships, employment, education, housing, community inclusion, physical health, etc).
- Has experienced a hospitalisation for mental health issues in the past or is at risk of hospitalisation if not supported.
- Is best supported in primary health care and is engaged with a GP or psychiatrist who are principally responsible for their clinical mental health care.

Referrer Details

Referrer name _____ Provider number _____
Address _____
Role/relationship _____ Email _____
Phone _____ Fax _____

Consumer Details

Full name _____
Preferred name _____ Date of Birth _____
Gender Male Female Other: _____
Street address _____ No fixed address
Suburb _____ Postcode _____
Phone _____ Mobile _____
Email _____
Preferred contact Phone Email SMS
Okay to leave voicemail? Okay to leave email?
Health Care card? Yes No Pension card? Yes No
Dept Veterans Affairs (DVA) Card? Yes No Expiry date: _____
Proficiency in spoken English Very Well Well Not Well Not at all NA
Interpreter required Yes No If yes, language: _____

Emergency Contact

Contact in the event of an emergency or if the referred person is unavailable. If the consumer is a child, provide the details of the responsible parent or guardian.

Primary contact _____ Relationship/role _____
Agency _____ Phone _____
Email _____

Consent to share information

The Privacy Act requires the applicant to sign this form giving their consent for the release of their information and details.

I give consent for Connect to Wellbeing to seek and share information concerning matters related to this application, with relevant **Local Health District services**, the **emergency contact** outlined in this form, and **other service providers** relevant to this referral.

Consumer signature (or Guardian/Parent if a child) _____ Date _____

The referrer agrees that all information submitted in this referral is an accurate reflection of the applicant's support needs, is correct with no information withheld and is necessary for Connect to Wellbeing to fulfill its duty of care to consumers, staff and other partner agencies.

Referrer signature _____ Date _____

What happens now

Fax this referral with a **Mental Health Treatment Plan and K10/K5/SDQ** (as applicable) to Connect to Wellbeing.
Fax numbers: **Cairns** 07 4214 5225 | **Townsville** 07 4409 2304 | **Mackay** 07 4829 4424 **OR**
Refer via **Medical Objects** (Connect to Wellbeing – Cairns, Townsville or Mackay)

A Connect to Wellbeing intake staff member will contact the person referred to validate the referral, and to schedule an appointment with a clinician to undertake an assessment.



Contact
Phone 1300 020 390
www.connecttowellbeing.org.au

APPENDIX A - Referral Information (where MHTP / CTP does not provide this information)



It is not necessary to complete Appendix A if a Mental Health Treatment Plan (MHTP) or Child Treatment Plan (CTP) accompanies this referral form and contains the information below.

Reason for referral (perspective of consumer and referrer)

Perinatal

Yes

No

Outcome measures (score)

SDQ

K10

K5

Mental health diagnosis (if known) / symptoms (or at risk of developing mental illness if child under 12)

Medication

Substance use

Other relevant history / factors (e.g. climatic events, disabilities, medical conditions, allergies)

Risk (describe if risk to self, if risk to others)

Health professionals involved in consumer's care (e.g. GP, allied health professional, psychiatrist)

Please attach any other relevant information or assessments if applicable/appropriate.

Fax completed referral form to **Cairns** 07 4214 5225, **Townsville** 07 4409 2304 or **Mackay** 07 4829 4424

OR Refer via **Medical Objects** (Connect to Wellbeing – Cairns, Townsville or Mackay)