North East Valley Division of General Practice
C/- Austin Health, Locked Bag 1, Heidelberg West, VIC 3081
T: 9496 4333 F: 9496 4349

Fax referral to: 9496 4349

This is a free service provided by the NEVDGP
The Mental Health Nurse will respond within 5 working days of receiving this referral

Referral to Mental Health Nurse

Patient details			
Name			
Address			
Tel /Mob			
Medicare No.			
DOB		**Gender**	

Referring Medical Practitioner Details			
Name			
Practice Name & Address			
Tel / Mob			
Provider No.			
Dr's signature		**Date**	

*Please **CIRCLE AN OPTION in ALL SHADED BOXES** below, or **INSERT 'X'** where indicated*

Entrance criteria *The patient should meet **ALL** entrance criteria*

Yes / No	The patient has a diagnosis of a mental health disorder				
Yes / No	The diagnosed disorder causes significant disablement to the patient's social, personal and occupational functioning				
Yes / No	The patient has been or is at risk of being hospitalised for their mental health disorder				
Yes / No	The patient is expected to require medical treatment and management of their mental health disorder over the next two years				
Yes / No	I am principally responsible for the patient's clinical mental health care *(Insert **X** in appropriate box)*		**GP**		**Psychiatrist**
Yes / No	The patient consents to treatment from a Mental Health Nurse				

Mental Health Treatment Plan

Yes / No	I understand that the patient's Mental Health Treatment Plan needs to include specific reference to the roles and responsibilities of both the Mental Health Nurse and the treating doctor and will be regularly reviewed.
Yes / No	The patient has a current Mental Health Treatment Plan. ***If Yes, please attach.*** *If No, go to next question*
Yes / No	I will develop a Mental Health Treatment Plan (or equivalent) within a 2 week period in collaboration with the Mental Health Nurse
Yes / No	Are there other current service providers? ***If Yes, provide name/s & ensure they are aware of this referral*** Name: Organisation:

Risk Assessment *(Risk assessment resources available through NEVDGP)*

Yes / No	Suicidal Ideation	**Yes /No**	Suicidal Intent	**Yes / No**	Risk to Others	**Yes / No**	Current Plan
Comment							
Yes / No	Are there any other relevant clinical notes? eg past or present alerts; discharge summaries; clinical reviews ***If Yes, please attach***						

Optimal program collaboration

Yes / No	I agree to give the Mental Health Nurse access to this patient's electronic patient record to record clinical assessment and progress notes
Yes / No	I am able to provide the necessary workspace in the clinic for the Mental Health Nurse
Yes / No	I am attaching the patient's medical history

Making first contact

I request that the Mental Health Nurse organise the first appointment by contacting the: *(Insert **X** in appropriate box)*		**GP**		**Psychiatrist**
		Patient directly		

Template developed by NEVDGP. Updated Oct 2009 with acknowledgement to General Practice North (Tasmania)