Well Connected Referral Form (Psychosocial Support)

Please attach any recent Initial Assessment and Referral Decision Support Tool assessments (IAR), K10+/K5's, safety plans, and risk assessments.

Date: _____

ELIGABILITY CRITERIA

- ◯ Severe episodic mental illness with associated impact on psychosocial functioning
- ◯ Would benefit from time limited psychosocial support
- ◯ Does not have an active NDIS plan
- ◯ Not receiving clinical case management from an area mental health service.
- ◯ Lives or works within Barwon and Colac Otway or Greater South Coast catchments

REFERRER DETAILS

Self Referral: ◯ No ◯ Yes *(If yes, please skip to consumer details)*

Referrer Name: _____ Relationship to Consumer: _____

Organisation: _____ Address: _____

Phone: _____ Email: _____

CONSUMER DETAILS

First Name: _____ Last Name: _____

DOB: _____ Gender: _____ Pronouns: _____

Phone: _____ Email: _____

Residential Address: _____

Homeless: ◯ Yes ◯ No Identifies as LGBTQIA+: ◯ Yes ◯ No ◯ Unknown / Prefer not to say

◯ Aboriginal ◯ Torres Strait Islander ◯ Culturally & Linguistically Diverse ◯ None of the above

Country of Birth: _____ Interpreter Required (If yes, please specify): _____

Income Source: _____ Health Care Card: ◯ Yes ◯ No

Worker Preference: ◯ No preference ◯ Female ◯ Male ◯ LGBTQIA+

EMERGENCY CONTACT

First Name: _____ Last Name: _____

Phone: _____ Relationship to Consumer: _____

NDIS

- ◯ Have not applied and needs support
- ◯ Applied and waiting access decision. Date of application: _____
- ◯ Applied and found to be ineligible. Wanting to re-apply: _____
- ◯ Does not meet eligibility criteria (due to age, residency etc) or does not intend to apply

CONSUMER INFORMATION

List current services (eg psychologist & GP) and informal supports (friends, family or carers):

Mental health diagnosis or presenting symtoms, and any relevant medications:

Current physical health conditions and any mobility/disability needs:

Addictive behaviours:

Impact of mental health on the following domains, please include psychosocial goals to address these barriers:

Managing daily activities and responsibilities e.g. self-care, cooking, parenting

Social skills, friendships and family relationships

Education/Employment

Physical Wellbeing

Life Skills e.g. self confidence, resilience

RISK ASSESSMENT

If presenting with an acute crisis or risk is high, please call your psychiatric triage service

Current suicidal thoughts: ◯ No ◯ Yes: _____

Current suicidal plan: ◯ No ◯ Yes: _____

Current suicidal intent: ◯ No ◯ Yes: _____

Recent suicide attempt in the last three months: ◯ No ◯ Yes: _____

Relevant history: _____

Suicide risk level: ◯ **Not apparent** ◯ **Low** ◯ **Medium** ◯ **High**

Current self harm thoughts: ◯ No ◯ Yes: _____

Current self harm plan: ◯ No ◯ Yes: _____

Current self harm intent: ◯ No ◯ Yes: _____

Current behaviours: ◯ No ◯ Yes: _____

Relevant history: _____

Self harm risk level: ◯ **Not apparent** ◯ **Low** ◯ **Medium** ◯ **High**

Current harm to others thoughts: ◯ No ◯ Yes: _____

Current harm to others plan: ◯ No ◯ Yes: _____

Current harm to others intent: ◯ No ◯ Yes: _____

Relevant history: ◯ No ◯ Yes: _____

Forensic history: ◯ No ◯ Yes: _____

Details: _____

Risk to others: ◯ **Not apparent** ◯ **Low** ◯ **Medium** ◯ **High**

Risk of harm from others: ◯ No ◯ Yes: _____

_____

_____

CURRENT RISK MANAGEMENT PLAN

◯ Yes, date of plan: _____

◯ No, preparation of plan will be completed on _____ by: _____

◯ N/A, please comment: _____

CONSENT TO CONTACT

Receiving mail to address listed on this referral	◯ Yes	◯ No
Having voice messages left on number provided on this referral	◯ Yes	◯ No
Receiving text messages	◯ Yes	◯ No

ADDITIONAL INFORMATION

_____

_____

_____

_____

_____

_____

CONSUMER CONSENT

	YES	NO
1. By consenting to services under this program the client understands that the GP/(other referrer or health professional) is required to provide some information to WVPHN, the service provider and other health professionals involved in their care to ensure service best meets their needs.	◯	◯
2. The client has consented to their personal information being collected/used/stored by Western Victoria Primary Health Network to assess eligibility, record and report on service delivery, evaluate programs and manage referrals. *If they say no: If the client does not consent to sharing their personal information with WVPHN they cannot progress with the provider and program. (If you need urgent care, we recommend you contact Lifeline on 13 11 14 or Beyond Blue on 1300 22 4363.)*	◯	◯
3. The client has been made aware of who to contact to withdraw their consent or to discuss any privacy concerns.	◯	◯
4. The client consents to receiving the experience surveys for their voluntary completion from either Western Victoria Primary Health Network or by an authorised third party.	◯	◯
5. The client consents to participating in program evaluation, as well as being contacted for this purpose by Western Victoria Primary Health Network or by an authorised third party.	◯	◯
6. As the funder of Psychosocial Support services and as authorised by Australian Privacy Principles, the Commonwealth Department of Health and Aged Care, state and territory health departments and evaluators need to know what kind of people are using the service and why, and for statistical and evaluation purposes designed to improve mental health services in Australia. This includes the use of personal information to generate a unique key, which can be used to link my de-identified data to other deidentified data to facilitate research. To support this, we need to tell the Department and third parties the Department engages how many people have contacted the service and we share generic de-identified details like your date of birth, gender, postcode and health outcomes. We will not share your name, address, Medicare number or other details that can be linked back to you. Is it ok to share your generic details? *Option if they say No: You have noted that you do not consent to sharing your generic details. We inform you that in accordance with the Privacy Act and Australian Privacy Principles we will provide the Department with deidentified aggregated data. This includes data about your use of the services, combined with information about other clients in summary reports with no identifying features at an individual level. As these do not require personal information, consent is not required.*	◯	◯
7. To give you the best coordinated care, we try to work together with your other care providers such as your doctor or psychologist. We might need to contact an existing care provider to discuss your future care planning. In contacting an existing care provider, we will need to share your personal details. If you do not consent to us sharing your personal details with an existing care provider, we are unable to do so and will not be able to provide you with the most suitable service. Are you OK with us contacting an existing care provider to discuss your future care planning?	◯	◯

Please list all the service providers, carers and supports you consent to being contacted by Well Connected to discuss your provision of support and planning (e.g., GP, psychiatrist, CAT team, allied health, family, friends etc)

PROFESSION	NAME	ORGANISATION	CONTACT DETAILS

WVPHN-funded services are at times involved in evaluation and research to ensure they are meeting the needs of consumers and our community. You may be contacted to participate in additional evaluation or research activities associated with your care. If contacted, you can choose whether you wish to partake.

1. I / parent / guardian consent to receive service and for the sharing of service delivery information, as outlined above. This consent condition is mandatory to receive services.
◯ Yes ◯ No

2. I / parent / guardian consent to share deidentified data with DoH and DHHS. I understand that my information will not be shared if I do not consent.
◯ Yes ◯ No

3. I / parent / guardian consent to the collection and sharing of all relevant information with other services, carers and supports relevant to assist my/dependent's overall provision of care. I understand that my information will not be shared if I do not consent.
◯ Yes ◯ No

Consumer signature or referrer signature:
(Verbal consent provided by consumer) _____ Date: _____

WELLWAYS TO COMPLETE

Meets eligibility criteria: ◯ No ◯ Yes

Date referral faxed to Western Victoria Primary Health Network: _____

Staff: _____ Signature: _____