

# Referral Form

## Brisbane North Medicare Mental Health phone service

medicare

**Mental Health**  
**1800 595 212**

Servicing people in the Brisbane North PHN catchment area. The Medicare Mental Health phone service provides a free, confidential referral service for anyone seeking help for their wellbeing or wanting support for a patient or someone they care about.

**Please note that Medicare Mental Health is not a crisis service.**

### Referrer Details

Referrer name \_\_\_\_\_ Role / Organisation \_\_\_\_\_  
Address \_\_\_\_\_ Suburb \_\_\_\_\_ Postcode \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_ \*Email \_\_\_\_\_

\*To receive notification that this referral has been allocated, email address is required

### Consumer Details

Full name \_\_\_\_\_ Preferred name \_\_\_\_\_  
DOB \_\_\_\_\_ Gender \_\_\_\_\_ Pronouns \_\_\_\_\_  
Address \_\_\_\_\_ Postcode \_\_\_\_\_  
☐ No fixed address Mobile \_\_\_\_\_ Email \_\_\_\_\_  
Interpreter required? ☐ Yes – Language \_\_\_\_\_ ☐ No

### Referral Support Person

Contact if the consumer is unavailable. If the consumer is a child, provide the details of the responsible parent or guardian.

Relationship/role \_\_\_\_\_ Full name \_\_\_\_\_  
Agency \_\_\_\_\_ Phone \_\_\_\_\_  
Email \_\_\_\_\_

### Consent to Share Information

The Privacy Act requires that the consumer sign this form to provide consent for the release of their information.

By signing below, the consumer gives consent for Medicare Mental Health to seek and share information concerning matters related to this application, with the Brisbane North PHN, the referral support person outlined in this form, and other service providers relevant to this referral. The consumer also gives consent to their information being used for statistical and evaluation purposes to improve mental health services in Australia. They understand that this will include details about them such as date of birth, gender and types of services they use, but will not include their name, address or Medicare/Pension/Health Care Card numbers.

Consumer signature \_\_\_\_\_ ☐ Or verbal consent  
Guardian/parent if child \_\_\_\_\_ ☐ Tick if applicable Date \_\_\_\_\_

The referrer agrees that all information submitted in this referral is an accurate reflection of the consumer's support needs and is correct with no information withheld, so Medicare Mental Health can fulfill its duty of care to consumers, staff and other partner agencies.

Referrer signature \_\_\_\_\_ Date \_\_\_\_\_

Please attach Mental Health Treatment Plan (MHTP) or Child Treatment Plan (CTP) if available

**Referral Notes** (Any additional information that may support the consumer and referral)

The consumer and/or the referrer may be contacted for additional information.  
All referred consumers will have an intake and assessment completed by Medicare Mental Health to determine service level and type (refer to: <https://iar-dst.online/>)

### **Submit Referral Form**

Submit form via the button above or E-Fax to 07 3103 4038.  
These e-faxes will go securely through to the shared mailbox for the team

Phone 1800 595 212 | [MedicareMHps.BN@neaminational.org.au](mailto:MedicareMHps.BN@neaminational.org.au)