

**Head to Health provides the following:**

*Referral is not required but helpful.*

- immediate mental health support for people in distress
- short- or medium-term mental health and wellbeing support
- service navigation and helpful, relevant information.

Providing support for adults across Penrith, 7 days a week, 365 days a year.

## Section 1

### Referral for

*Please select one type of support and preferred way of attending Head to Health.*

- Support for mental health distress or crisis
- the person will attend in person
  - for phone contact within 24 hours (inc wknds)
- Information, advice, connection and referral for ongoing support, including telehealth access to psychiatry consultation
- the person will attend in person
  - for phone contact within 7 days
- Short- or medium-term mental health support
- the person will attend in person
  - for phone contact within 7 days

Referral date .....Time .....

### Referrer details

Referrer name.....

Service .....

Provider number/link code .....

Role/Relationship .....

Email.....

Phone/Fax.....

### Person details

Full name.....

Preferred name .....

Gender..... Pronouns.....

Date of Birth

Street address.....

.....

Suburb ..... Postcode.....

No Fixed Address

Phone/Mobile.....

Email.....

Preferred contact:  phone  email  sms

Okay to leave: .....  voicemail  email  sms

Interpreter required  Yes  No

Language.....

Continue ----->

### Section 1 - continued

#### Emergency contact

Contact in the event of an emergency or if the referred person is unavailable

Primary contact.....

Relationship/role .....

Agency .....

Phone.....

Email.....

Preferred contact:  phone  email  sms

Okay to leave: .....  voicemail  email  sms

#### 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 Penrith Head to Health to seek and share information concerning matters related to this application, with relevant local services, the emergency contact outlined in this form, and other service providers relevant to this referral.

#### Signature of person being referred:

..... 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 [region] Head to Health to fulfill its duty of care to service users, staff and other partner agencies.*

#### Referrer signature:

..... Date .....

### Section 2

Reason for referral (please include perspective of both person and referrer; diagnosis and symptoms if known; context)

Please attach Mental Health Treatment Plan OR complete referral information below

Psychological distress score (if completed) K10..... K5 .....

Information Assessment and Referral Decision Support Tool (IAR) score if known.....

(Visit <https://iar-dst.online/#/>)

## Section 2 - Continued

Current treatment/medication

Other relevant history or important information (medical conditions, substance use, allergies)

Any safety issues (for the person or for others)

Health/social care supports – others involved



Penrith Head to Health acknowledges the Traditional Custodians of the land we work on and pays its respects to Elders past, present and emerging.



We celebrate, value and include people of all backgrounds, genders, sexualities, cultures, bodies and abilities.