phn NORTH WESTERN MELBOURNE
An Australian Government Initiative

neami national
Improving Mental Health and Wellbeing

Northern CPS Referral Form

Please email completed form to NorthernMelbournePSS@neaminational.org.au or fax to **03 9309 4843**.

Attach all relevant documents, including (if available): Mental Health Care Plan, assessment notes, outcome measures, discharge summary, and/or current risk management plans.

Date of Referral:

Eligibility Criteria

*Consumers must meet all criteria to be eligible for this service. If unsure about eligibility, contact intake on **1300 052 588**.*

Severe episodic mental illness with associated impact on psychosocial functioning

Would benefit from time-limited psychosocial support

Not currently supported with Case Management from an Area Mental Health Service

Lives or works within the NWMPHN catchment (Darebin, Yarra, Hume, Merri-bek, Mooney Valley, City of Melbourne and Macedon Ranges LGAs)

No Active NDIS Funding in place

ndis NDIS Application Status

☐ Ineligible due to age / residency

☐ Applied and waiting for access decision

☐ Needs support to apply/re-apply (provide details below)

☐ Does not intend to apply (provide details below)

Comments:

Referrer Details

Name		Relationship to consumer:	
Organisation			
Address			
Phone		Email:	

Consumer Details

Full Name		Preferred Name	
Date of Birth		Country of Birth	
Gender		Pronouns	
Phone		Email	
Address		Postcode:	
I **do not** wish to be contacted via (please select if appropriate): Phone Email Mail			
Worker preference (eg: gender)		Do you identify as LGBTIQA+?	☐Yes ☐ No ☐Prefer not to say
Country of birth		Interpreter Language	

Do you identify as (please select)	Aboriginal Torres Strait Islander Neither Aboriginal or Torres Strait Islander		
Do you identify as Culturally and Linguistically Diverse	Yes No Prefer not to answer	Have you experienced homelessness?	Yes Yes, in the last 4 weeks No Comments:
How would you best describe your relationship status?			

Emergency Contact

Name		Relationship to consumer:	
Phone		Email:	

Consumer Information

Neami's Commonwealth Psychosocial Support Service is a time limited service and as such we encourage you to include as much information as possible to support us with determining the eligibility and level of support required.

Mental health diagnosis (if known), presenting mental health needs and medications

Physical Wellbeing (eg. Chronic Conditions)
As part of receiving Psychosocial Support consumers are offered support through the Integrated Chronic Care Program embedded within the service. This brief support focuses on supporting consumers with physical health goals centred around chronic health conditions. Please list health goals below in addition to any physical health diagnoses and date of diagnosis:

Addictive behaviours

Managing daily activities and responsibilities (eg. Self care, cooking, parenting)

Social Skills, Friendships, and Family Relationships

Are you interested in groups ☐Yes ☐ No
What type of group?

Education/Employment

Which best describes your employment status?

Employed

Unemployed

Not in the Labour Force

Life Skills (eg. Self-confidence, Resilience)

Current and Previous Services (eg. Psychologist, GP) and informal supports (family, friends)

Reason for referral ***(As we are a time limited service, are there any specific psychosocial goals/needs that you would like to work on?)***

Risk Assessment

If presenting in an acute psychiatric crisis or risk is high, call your local area mental health service

Suicide

Current Suicide Thoughts	
Current Suicide Plan	
Current Suicide Intent	
Suicide Risk Level	
Comments/Relevant History	

Self-harm

Current Self-harm Thoughts	
Current Self-harm Plan	
Current Self-harm Intent	
Self-harm Risk Level	
Comments/Relevant History	

Harm to others

Current Self-harm Thoughts	
Current Self-harm Plan	
Current Self-harm Intent	
Self-harm Risk Level	
Comments/Relevant History	

Harm from others – including Family Violence

Risk of Harm from Others	
Comments/Relevant History	

Please attach any current risk management plans to this referral.

Consent:

Neami National are required to collect and use information about you. This includes personal information, and information about the services you are receiving. This information is used by staff members involved in delivering services to you. This information is used and shared to ensure you get the right service for your needs, to monitor service delivery and performance, and evaluate and make improvements to services. *If consent is withheld, service provision may be limited.*

I understand my personal information will not be shared otherwise, unless:

- Consent to my information being shared;
- There is a serious threat to my safety, the safety of another person, or the public, and obtaining my consent is not reasonable or practical; or
- A disclosure is required by law.

○ Yes ○ No

I understand I have a right to request access to my information. If I disagree with information in the file, or I have a question or complaint about what happens to my information, I can discuss this with my support worker.

○ Yes ○ No

Consent to collect and share information with other services

I (or parent/guardian) consent to the collection and sharing of all relevant information with the listed service providers below to assist my (or my child's) overall care. I understand that my information will not be shared if I do not consent.

○ Yes ○ No

Service provider type	Name	Organisation	Contact (phone/email)

The Commonwealth Department of Health and Aged Care, state and territory health departments and evaluators need to understand who have contacted the service and share some de-identified personal information like date of birth, gender, postcode, and health outcomes. This de-identified personal data can also be linked to other available de-identified data about you to facilitate research. The service does not share your name, address or other personally identifiable details that can be linked back to you.

Is it ok to share these de-identified personal details?

[ ] Yes, I (consumer) consent to the sharing of some of my information with the funders of this service, the Department of Health, state and territory health departments and independent evaluators.

[ ] Yes, consumer has provided verbal consent.

[ ] No, I do not consent.

NWMPHN funded services are evaluated to ensure they are meeting the needs of consumers and our community. You may be contacted to participate in additional evaluation activities associated with your care. If contacted, you can choose whether you wish to take part or not.

Consumer signature ______________________________ Date ____________

☐ Verbal consent provided by consumer instead of written consent

Referrer signature ______________________________ Date ____________