GP / Psychiatrist Referral form

### About Step Thru Care

### Step Thru Care - Geelong Otway’s offers free mental health and/or alcohol and drug (AOD) support. Step Thru Care provides support in one place, which means people experiencing mental health or substance use challenges, or a combination of both, don’t need to retell their stories to multiple services. The Step Thru Care team have diverse backgrounds and expertise, including specialising in mental health, AOD and LGBTIQA+ specific challenges. This helps to create a culturally safe, accessible and inclusive service. The team is made up of mental health and AOD clinicians, child and family practitioners, multicultural practitioners, care recovery coordinators, and peer support workers who have lived experience of mental health and substance use challenges.

Step Thru Care offers a recovery focused approach by providing:

* Education
* Group therapies
* Emotional support
* Evidence-based therapies
* Care coordination.

### Eligibility Information

People who are eligible:

* Low income, e.g. healthcare/concession card holders
* Living rural or remote
* People who identify as LGBTQIA+, aboriginal and/or Torres Strait Islander peoples
* People from Culturally and Linguistic (CALD) backgrounds
* Children under the age of 12 years
* People experiencing perinatal depression
* People experiencing or at risk of domestic violence
* People with an intellectual disability and who are experiencing AOD and/or mental health issues
* Young people who do not access to other appropriate services.

Receiving STC service is not duplicative of other services.

Those who do not fit into the above criteria should be encouraged to seek appropriate services.

Please note: people aged 12–25 should be referred to Headspace in the first instance.

**Please include any supporting documentation if available, e.g. K10, IAR, SDQ.**

### Consumer Information

|  |  |  |
| --- | --- | --- |
| Title e.g. Mr |  | First Name [Insert first name] |
| Preferred Name [Insert preferred name] |  | Last Name [Insert last name] |
| Date of Birth 1/1/2024 |  | Gender [Insert gender] |
| Pronoun e.g. She / her |  | Address [Insert home address] |
| Contact Number 0400 000 000 |  | Email [Insert email address] |
| Country of Birth e.g. Iran |  | Main Language Spoken e.g. Farsi |
| English Proficiency |  | Interpreter Required  Yes   No |
| ATSI Status |  | Homelessness |
| Intersex |  | Sexual Orientation |
| Labour Force Status |  | Employment Participation |
| Income Source |  | Marital Status |
| Health Care Card  Yes   No |  | NDIS Participant  Yes   No |
| Consent to share information  Yes   No |  |  |

### Emergency or Support Person Contact

|  |  |  |
| --- | --- | --- |
| First Name [Insert first name] |  | Last Name [Insert last name] |
| Phone Number 0400 000 000 |  | Relationship to you [Insert relationship] |
| First Name [Insert first name] |  | Last Name [Insert last name] |
| Phone Number 0400 000 000 |  | Relationship to you [Insert relationship] |

### Current Supports

**Personal**

|  |  |  |
| --- | --- | --- |
| Name [Insert name] |  | Phone Number 0400 000 000 |

**Service support**

|  |  |  |
| --- | --- | --- |
| Name [Insert name] |  | Phone Number 0400 000 000 |
| Email Address [Insert email address] |  |  |

### Child/Youth Referrals

|  |  |  |
| --- | --- | --- |
| Guardian Name [Insert full name] |  | Contact Number 0400 000 000 |
| Does the child/youth reside  with the guardian?  Yes   No |  | If no, where does the child/youth reside? [Insert carer address] |
| Carer Name [Insert full name] |  | Carer Number 0400 000 000 |
| Are there any court orders?  Eg FLC, IVO, DFFH (please attach copies)   Yes   No |  | Comments |
| Is the child/young person aware this referral is being made?   Yes   No |  |  |

### Referrer

|  |  |  |
| --- | --- | --- |
| Referrer Profession |  | Referrer Name  [Insert referrer name] |
| Referrer Phone 03 0000 0000 |  | Referrer Fax  03 0000 0000 |
| Referrer Email [Insert Email] |  |  |
| Referrer Organisation |  | Organisation Name [Insert organisation name] |

### Suicide Risk Assessment

|  |  |  |
| --- | --- | --- |
| Suicide Prevention Referral  Yes   No |  | Previous suicide attempt?  Yes   No |
| Recent attempt?  Yes   No |  | When [Insert context] |

### Mental Health & AOD

|  |
| --- |
| Principal Diagnosis [Insert principal diagnosis] |
| Additional Diagnosis [Insert additional diagnosis] |
| Legal Proceedings?  Yes   No |
| Details [Insert details of legal proceedings] |

#### Please advise of medications

|  |  |
| --- | --- |
| Antipsychotics?  Yes  No  Not stated  Unknown | |
| Anxiolytics?  Yes  No  Not stated  Unknown | |
| Hypnotics?  Yes  No  Not stated  Unknown | |
| Antidepressants?  Yes  No  Not stated  Unknown | |
| Psychostimulants?  Yes  No  Not stated  Unknown | |
| AOD use [Insert AOD use] | |
| Primary drug of concern [Insert primary drug of concern] | |
| Quantity [Insert quantity] | |
| Secondary drug of concern [Insert secondary drug of concern] | |
| Quantity [Insert quantity] |

**Reason for Referral**

[Insert reason for referral]

**Referrer EDI Number**

[Insert EDI number]

|  |
| --- |
| **Please email referral to** [**stepthrucare@neaminational.org.au**](mailto:stepthrucare@neaminational.org.au?subject=Self%20Referral%20form) **or fax to 03 5229 5286. If you are sending via email, please ensure the document is password protected.** |
| Please note: Step Thru Care is not a crisis service. Please call the Barwon Health ACCESS Team on  1300 094 187 where acute risk is present. |