



Mental Health Nurse Service Referral Form

Practice Stamp:

Date: _____
GP Name: _____
Practice: _____
Phone No: _____
GP Provider No: _____

Patient Details:

Gender: Male Female

First Name: _____

Last Name: _____

Address: _____

D.O.B: _____

Medicare No.: _____

Day time telephone: _____

Mobile: _____

The patient gives consent to treatment from a Mental Health Nurse. Yes

Risk (to self/others, including suicidal ideation/intent, previous attempts).

To be eligible for this service, the client MUST meet ALL the criteria in questions 1 through to 6.

If unsure, please speak to the Mental Health Nurse prior to referral.

- 1. Diagnosed Mental Disorder (please specify): _____
- 2. Diagnosed disorder causes significant disablement to the patient's social, personal or occupational function?
- 3. The patient has been hospitalised or is at risk of hospitalisation in the future if appropriate treatment and care is not provided? (Please attach most recent discharge summary)
- 4. The patient will require continuing treatment and management over prolonged period?
- 5. The GP is principally responsible for this patient's clinical mental health care. (NB: a person who is under the care of public mental health services is not eligible for this service)
- 6. The patient has a current Mental Health Treatment Plan (item 2710) (Please attach)
- 7. Estimated level of severity and impact of the mental health disorder: High Moderate Low
- 8. Estimated frequency of service utilisation for Mental Health Nurse:
 Weekly Fortnightly Monthly Other: _____
- 9. Details of other service providers (Psychologists, Psychiatrists and Case Workers):

Name: _____

Organisation: _____

Ph: _____

Name: _____

Organisation: _____

Phone: _____

PLEASE FAX THIS FORM TO KNOX DIVISION OF GENERAL PRACTICE ON (03) 9764 9828