Healthscope

OUTPATIENT PROGRAMS MENTAL HEALTH ASSESSMENT AND REFERRAL

(to be used for patients NOT currently engaged in outpatient programs)

Attach patient identification label

Patient Details

UR Number: .....

Surname: .....

Name: .....

Date of Birth: ..... Gender: .....

Dr: .....

Private Health Fund: *Membership Number:*

Inpatient Discharge date (if applicable): *Workcover:* ☐ *TAC* ☐ *DVA* ☐ *Other Compensation*

Patient's Address:

Phone – Home *Mobile* *Email Address*

DIAGNOSIS

1

2

3

REASON FOR REFERRAL / TREATMENT GOALS:

☐ Yes ☐ No Patient suitable for telehealth services as required

Psychiatric history and management (attach relevant information such as inpatient assessment / reports where available)

Substance Use History / Addictive Behaviours

Medical History

Family & Support Systems

Family Support: ☐ Good ☐ Limited ☐ Poor

Social Support / Network: ☐ Good ☐ Limited ☐ Isolated

Please note any further information:

PSYCHIATRIC CARE IN COMMUNITY: Managed by (must see Accredited Hospital Psychiatrist at least 3 monthly)

Phone *Mobile* *Fax*

Community involvement

☐ Public health system ☐ Agency & CASA ☐ DHS

BINDING MARGIN – DO NOT WRITE IN THIS AREA

HS000262

Print Media Group HSHGXFMR0520 07/24

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Patient Details

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Surname: .....

Name: .....

Date of Birth: ..... Gender: .....

Dr: .....

CURRENT CLINICAL RISK TO PATIENT SAFETY:

Risk Rating: L = Low M = Moderate H = High risk – Rating H not suitable for Outreach or Day Program

RISK	*RATING*			*DETAILS*
Suicidality	*L*	*M*	*H*	
Other Self Harm	*L*	*M*	*H*	
General Vulnerability	*L*	*M*	*H*	
Aggression / Harm to Others	*L*	*M*	*H*	
Judgment	*L*	*M*	*H*	
Impulsivity	*L*	*M*	*H*	
Insight	*L*	*M*	*H*	
Forensic History / Pending Legal Issues	☐ *Yes*	☐ *No*		*Details* _____
Predatory	☐ *Yes*	☐ *No*		*List* _____

Medication	*Dose*	*Medication*	*Dose*

Compliance ☐ *Good* ☐ *Intermittent* ☐ *Poor*

Side Effects & Sensitivities

Precautions ☐ *Overdosing* ☐ *Hoarding* ☐ *Self Medicating*

Other

PROGRAM OPTIONS – Please (✓) programs and, where relevant, specialist streams required for this patient.

DAY PROGRAMS: Site to drop in DP / OR information - please reference site-specific form (to track changes to program offerings): _____

SITE / FACILITY / HOSPITAL:

- ☐ *OUTREACH*
- ☐ *DAY PROGRAM: (Please tick following)*
- ☐ *Assessed as Appropriate for Telehealth*
- ☐ *Anxiety and Depression Management (ADM)*
- ☐ *Adult ADHD*
- ☐ *OCD*
- ☐ *Emotional Management (EMDP)*
- ☐ *Dialectical Behaviour Therapy (DBT)*
- ☐ *DBT Creatively*
- ☐ *Young Adults DBT (DBTYAF)*
- ☐ *Recovery, Identity, Self-Acceptance and Empowerment (RISE)*
- ☐ *PTSD 000 for Emergency Services*
- ☐ *Acceptance and Commitment Therapy (ACT)*
- ☐ *ACT in Practice*
- ☐ *ACT Graduates*
- ☐ *ACT Creatively*
- ☐ *Deepening Mindfulness*
- ☐ *Mindful Self Compassion*
- ☐ *Addictive Behaviours*

By referring this patient, you agree to be responsible for the care and wellbeing of this patient in all matters relating to their Day Program participation, attendance, and / or mental state. Crisis care may also be sought if deemed necessary during the Day Program admission. Please provide your most direct contact number below.

Phone: _____ Emails will also be sent to you for non urgent matters.

VMO's Signature: _____ Date: _____

Thank you for your ongoing support of the Day Program.

Admin use

- ☐ Health fund check completed
- ☐ Booked into system
- ☐ Communication with psychiatrist
- ☐ Patient informed of HFC
- ☐ Communication with patient

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