

Referral form and mental health treatment plan to be sent directly to the Mental Health Nurse.

Referral Date	Patients initials	Year of Birth	M / <u>F</u> Other	Postcode
05/07/2024	Julie	1971		2756

MHNIP Referral Details:

Referral Code	Nurse Name	Phone	Fax / Email
MBM 12185	Michelle HOOKHAM	0431 266 144	

Eligibility Criteria (The patient must meet all of the criteria to be eligible for MHNIP)

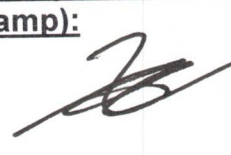

Criteria 1*	Criteria 2*	Criteria 3*	Criteria 4*
<input type="checkbox"/> The patient has been diagnosed with an eligible mental health disorder: List diagnosis:	<input type="checkbox"/> The disorder causes significant disablement to the patients social personal and occupational functioning	<input type="checkbox"/> the patient is expected to require continuing treatment and management of their mental health disorder over the next two years	<input type="checkbox"/> The patient has experienced at least one episode of hospitalization for treatment of mental health disorder, or is at risk of requiring hospitalisation in the future if appropriate treatment and care is not provided

Additional information to support patient:

Does the patient speak a language other than English?	Y
Does the patient live alone?	
Has the patient received specialist mental health care before?	<u>Public</u> , Private, Medical, Allied Health
Is the patient receiving medication?	Benzodiazepines, Anti-Depressants, Antipsychotics, Mood Stabilisers
Is there a history of aggression (physical or verbal) towards health professionals? (For safety assessment purposes. Will not affect acceptance of referral)	

Reason For Referral

<p>Patient Consent: By consenting to this referral, I understand that all information in this referral, and any previous referrals (where applicable) including my personal information, will be collected for the primary purpose of delivering care; and for the ongoing monitoring, reporting, evaluation and improvement of services. I consent with the understanding that this information will only be used, disclosed and stored for its primary purpose, between my health service provider(s), the Department of Health, and the Nepean Blue Mountains Primary Health Network (NBMPHN) and affiliated partner organisation(s)*, in accordance with the Australian Government Privacy Act, 1988.</p> <p><i>* Affiliated partner organisation(s) means those required to support the monitoring, reporting, evaluation and/or clinical governance for the service.</i></p> <p>Patient Signature /Date:</p>
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<p>GP signature (provide GP Details or stamp):</p> <p> 05/07/2024</p> <p></p> <p>ADVANCE MEDICAL PRACTICE Dr Zakir Parvez MBBS, FRACGP, Dip.Child Health Provider No: 249517MY Riverview Shopping Centre Shop 26, 227 George St, Windsor 2756 Tel: 02 4577 2677 Fax: 02 4577 9722</p>
