# Mental Health Triage Service: 13 14 65

* Required fields to fill in

Please ( ) if applicable
Further Information/ Reports are attached

EMERGENCY REFERRAL FORM FROM.....
.....
.....
.....

*Consumer Details: (URN):
Surname: Given Name:
D.O.B. Male/Female ATSI ☐
Address: Ph:
Mbl:
Diagnosis:
Support Name: Ph:
Mbl:

## Referrer's Details

| Name: | Organisation: |
|---|---|
| Ph: Fax: | |

## General Practitioner Details

| Name: | Ph: Fax: |
|---|---|
| Address: | |

Tick ( ) relevant box for each domain. For full descriptions of the following criteria refer to Policy Manual under "Risk Assessment"

See back of form for Risk Assessment Guide

| RISK OF HARM TO SELF OTHERS BOTH | | | | |
|---|---|---|---|---|
| None ☐ | Low ☐ | Moderate ☐ | Significant ☐ | Extreme ☐ |

| LEVEL OF PROBLEM WITH FUNCTIONING | | | | |
|---|---|---|---|---|
| None/Mild ☐ | Moderate ☐ | Significant Impairment in one area ☐ | Serious Impairment in several areas ☐ | Extreme Impairment ☐ |

| LEVEL OF SUPPORT AVAILABLE | | | | |
|---|---|---|---|---|
| No problems/Highly Supportive ☐ | Moderately Supportive ☐ | Limited Support ☐ | Minimal ☐ | No support in all areas ☐ |

| HISTORY OF RESPONSE TO TREATMENT | | | | |
|---|---|---|---|---|
| No Problem/ Minimal Difficulties ☐ | Moderate Response ☐ | Poor Response ☐ | Minimal Response ☐ | No Response ☐ |

| ATTITUDE AND ENGAGEMENT TO TREATMENT | | | | |
|---|---|---|---|---|
| No Problem/ Very Constructive ☐ | Moderate Response ☐ | Poor Engagement ☐ | Minimal Response ☐ | No Response ☐ |

| OVERALL ASSESSMENT OF RISK | LOW ☐ | MEDIUM ☐ | HIGH ☐ | EXTREME ☐ |
|---|---|---|---|---|

**Clinical Information/Reason for Referral:**

.....
.....
.....
.....
.....

*Firearms Notification Yes ☐ No ☐
*Child Protection Notification Yes ☐ No ☐

*Sent on.....
(Referrer completes date faxed)

*Name.....

*Signature.....

Current Medication(s):

| Medication | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

AT RISK REFERRAL/FEEDBACK FORM

*Received by.....
(Print Name)

*Immediate Action Taken.....
.....
.....

ACTION

*Management Plan.....
.....
.....
.....
.....

Print Name..... Date.....
(ED/MHS Service Provider)

FINAL PLAN

Developed By ANDGP 9/11/04 Revised 12/9/05 and 21/11/07