Access Mental Health Service
Phone: 1800 332 388

Tasmanian Government

TASMANIAN HEALTH SERVICE

Region	Email:	Fax
South	acstriagesouth@ths.tas.gov.au	03 6173 0306
North	acstriagenorth@ths.tas.gov.au	03 6173 0859
North West	acstriagenorthwest@ths.tas.gov.au	03 6464 1963

PLEASE NOTE:

This form should be utilised to make a referral to community based public mental health services state-wide for all individuals 18 years or older. Please note if this referral is for children under 18 years – please contact Child & Adolescent Mental Health Service (CAMHS) at **(03) 6166 0588** to request a CAMHS Referral form. Please email or fax the completed form to Access Mental Health (available all hours) with all relevant reports. Please send to the relevant region if possible.

Clear writing and current contact details are appreciated to avoid any delay in progressing this referral. Please use the pdf version and a typed form would be appreciated. Any confidential or urgent issues can be notified by telephone **1800 332 388.**

Patient Details		
Name		
DOB		
Address		
Postcode		
Phone		
Mobile		
Next of Kin (NOK)/Carer		
NOK/Carer Phone		
Cultural Background		
Preferred Language		
Interpreter needed	☐ Yes	☐ No
Indigenous or Torres Strait Islander	☐ Yes	☐ No

Referrer Details		
Name		
Address		
Phone		
Fax		
Profession		
Length of Referral	☐ Indefinite	☐ Other
Referral Date		

Part A

1. **Is the person aware of this referral?** ☐ YES ☐ NO
2. **Reason for Referral to Mental Health Services** (*Please tick all boxes that apply*)
   - ☐ Assessment and MHS to manage
   - ☐ Assessment and co-management
   - ☐ Medication advice and continued GP management
   - ☐ Assessment and suggestions for GP to manage
   - ☐ Other

a. Urgency

☐ Routine
☐ Urgent (*Please indicate below what risk factors make this referral urgent*)

b. **Presenting Problems**

c. Risk Factors

☐ Current suicidal thought/expressed intent
☐ Harm to others
☐ Alcohol and Drug Use
☐ Care of Children
☐ Work at Risk
☐ Patient has plans/ meant to attempt suicide
☐ Driving Risk
☐ Other

Additional Information

3. Mental Health Review

Sleep	☐ Early Morning Wakening	☐ Poor Sleep	☐ No Sleep	☐ Problem Duration
Appetite	☐ Significant weight loss	☐ Mild loss	☐ Excessive/Unhealthy weight gain	
Energy and Motivation	☐ Lack of energy	☐ Loss of motivation	☐ Mild anhedonia	☐ Marked anhedonia
Mood	☐ Abnormally low mood	☐ Elevated mood	☐ Irritability	☐ Abnormal mood changes
Delusions and hallucinations	☐ Delusional ideas	☐ Paranoia	☐ Hallucinations	☐ Command hallucinations

Further information	
Other important factors	
Mental Health History	
Relevant Medical History	
Social History	
Current Medications	

PART B – Adults Aged 65 + *(please complete this section only when referring adults aged 65 years and older)*	
Does this person live alone?	☐ YES ☐ NO
Is this person aware of this referral?	☐ YES ☐ NO
Is the person caring someone else?	☐ YES ☐ NO
Can they travel to an appointment?	☐ YES ☐ NO
Who is the initial contact person?	
Has this person been seen by ACAT or other services	☐ YES ☐ NO
Details of ACAT or other services	
If yes, are there any cognitive assessments (e.g., MOCA), pathology results or neuroimaging results available?	Please attach any new assessments or investigations.
Are you aware of any enduring or appointed guardianship and/or administration orders for this patient?	☐ YES ☐ NO
Does this person have their medication/s supervised?	☐ YES ☐ NO
Does this person have a “Community Pharmacy Packaging”	☐ YES ☐ NO
Is there a cognitive screening	☐ YES ☐ NO
Recent Investigations / General medical conditions	Please attach

Reset