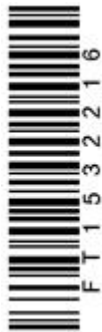




Access Mental Health Service

Phone: 1800 332 388

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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Indigenous or Torres Strait Islander	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Referrer Details		
Name		
Address		
Phone		
Fax		
Profession		
Length of Referral	<input type="checkbox"/> Indefinite	<input type="checkbox"/> Other
Referral Date		

Part A

1. Is the person aware of this referral?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Reason for Referral to Mental Health Services (Please tick all boxes that apply)		
<input type="checkbox"/> Assessment and MHS to manage	<input type="checkbox"/> Assessment and co-management	
<input type="checkbox"/> Medication advice and continued GP management	<input type="checkbox"/> Assessment and suggestions for GP to manage	
<input type="checkbox"/> 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	<input type="checkbox"/> Early Morning Wakening	<input type="checkbox"/> Poor Sleep	<input type="checkbox"/> No Sleep	<input type="checkbox"/> Problem Duration
Appetite	<input type="checkbox"/> Significant weight loss	<input type="checkbox"/> Mild loss	<input type="checkbox"/> Excessive/Unhealthy weight gain	
Energy and Motivation	<input type="checkbox"/> Lack of energy	<input type="checkbox"/> Loss of motivation	<input type="checkbox"/> Mild anhedonia	<input type="checkbox"/> Marked anhedonia
Mood	<input type="checkbox"/> Abnormally low mood	<input type="checkbox"/> Elevated mood	<input type="checkbox"/> Irritability	<input type="checkbox"/> Abnormal mood changes
Delusions and hallucinations	<input type="checkbox"/> Delusional ideas	<input type="checkbox"/> Paranoia	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Is this person aware of this referral?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Is the person caring someone else?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Can they travel to an appointment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Who is the initial contact person?		
Has this person been seen by ACAT or other services	<input type="checkbox"/> YES	<input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Does this person have their medication/s supervised?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Does this person have a “Community Pharmacy Packaging”	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Is there a cognitive screening	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Recent Investigations / General medical conditions	Please attach	