PROVISIONAL REFERRAL

Psychological Support Services (PSS)

THIS IS NOT A CRISIS SERVICE, if crisis assistance is required, please call the Mental Health Access Line on 1800 011 511.

Please FAX Completed referrals to CESPHN Intake on: (02) 9330 9988

DATE OF REFERRAL / /

Program Eligibility ***(please check each item - patient must meet each criteria below to be referred)***

☐ Client lives, works or goes to school in Central or Eastern Sydney region
☐ Client has NOT accessed Medicare rebated psychological services this calendar year under Better Access
☐ Client unable to access available services, including Better Access
☐ Client is experiencing mild to moderate mental health concerns
☐ Client would benefit from short term psychological intervention
☐ Client is not better suited to crisis or specialist domestic violence services and is not involved in any court proceedings

Provisional Referral Type

☐ Young person (12 – 25 years old)
☐ Woman experiencing perinatal depression
Baby's Date of Birth
☐ Has attempted, or is at risk of suicide, or self-harm (non-acute)
☐ Culturally and Linguistically Diverse (CALD) background
☐ Aboriginal and/or Torres Strait Islander

REFERRER DETAILS

Name		Position	
Organisation Name		Postcode	
Phone		Fax	
E-mail			

**** please note that if an e-mail address is not provided you will not receive referral confirmation.*

CLIENT DETAILS

First Name		Last Name	
Marital Status	☐ Never Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Married		
Date of Birth		Gender	☐ Male ☐ Female ☐ Other
Address			
Suburb		Postcode	
Phone 1		Phone 2	
Healthcare Card	☐ Yes ☐ No	NDIS Participation	☐ Yes ☐ No
Aboriginal and/or Torres Strait Islander	☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Unknown		
Country of Birth		Cultural Identity	
Main language spoken at home			
Proficiency in spoken English	☐ Very well ☐ Well ☐ Not Well ☐ Not at all		

DESCRIPTION OF PRESENTING COMPLAINT(S)/PROBLEM(S): Please provide as much information as possible (e.g. psychological/emotional/behavioural/physical/social problems) *N.B. Please attach additional information or copies of assessments if available.*

RISK ASSESSMENT: If risk is high please refer to the Mental Health Access Line on: **1800 011 511**			
Suicidal thoughts	☐ Yes ☐ No	Suicidal intent	☐ Yes ☐ No
Current plan	☐ Yes ☐ No	Recent Attempt	☐ Yes ☐ No
Self-Harm	☐ Yes ☐ No	Risk of harm from others	☐ Yes ☐ No

CLIENT PREFERRED PSS PROVIDER NAME (Subject to availability and may be left blank): Directory available at https://www.cesphn.org.au/directories-search-form	
1.	
2.	

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Name		Phone	
Relationship		Permission for CESPHN and/or Mental Health Professional to contact	☐ Yes ☐ No

CLIENT CONSENT: *Referral cannot proceed without client consent*

☐ *Referrer confirms that the client consents to the following:*

- Client understands and agrees to the above PSS referral
- Client agrees to their clinical and non-clinical information being shared with the PSS Provider Organisation and Mental Health Professional that their referral is allocated to
- Client understands that they will be contacted by the allocated PSS Provider Organisation or Mental Health Professional to arrange an appointment
- Client agrees to their clinical and non-clinical information being shared with CESPHN for administrative and project evaluation purposes
- Client agrees to their anonymised data being shared for administrative and project evaluation purposes
- Client understands that they may be contacted by CESPHN or its representative to complete a client experience of care survey

REFERRER SIGNATURE:		**DATE:**	/ /