	Re (name): **DOB:** **IWC Indigenous Stepped Care (ISCP)** **Mental Health Referral Form** **For further information on Stepped Care services, please see HealthPathways.** **For any questions, please call IWC on 1300 492 492 or email indigenoussteppedcare@iwc.org.au** **Please send via:** **Medical Objects: SI46700007L** **Fax: 07 3811 6459**

Referrer Details

Referrer Name:		Date of Referral:	
Referrer Position/Profession:		Referrer Provider Number:	
Name of referring practice:		Referrer phone:	
Referrer Address:			

Client Information

Has client given consent for referral? **<Has the patient given consent for a referral to the Central Intake team, for assessment and triaging into a Mental Health Stepped Care Service stream?>**

Client Name:						
DOB:		Age:		Sex:		
Ethnicity:		Preferred Language:		Interpreter required		
Address:						
	Suburb:		Postcode:			
Client Contact Details	**Mobile:**					
	Home:					
	Work:					
	Email:					
Medicare No.			DVA number			
Health Care Card No			Private Health No.			
Marital Status:						
Medication:						
Allergies:						

Risk Information

Current suicidal ideation? Past suicide attempt? In the past 7 days?	Self- harm? Mental health hospital admission in the last 12 months? Risk of harm to others?

Demographic Information

Rural and Remote resident		Culturally and Linguistically Diverse background	
Aboriginal and/or Torres Strait Islander		LGBTIQ community member	>
Female with Perinatal depression		Financially disadvantaged (e.g. concession card holder)	
Affected by Domestic Violence		Homeless (e.g. sleeping rough or couch surfing)	
NDIS participant		DVA card holder	
Private health insurance		To your knowledge, has the patient seen a psychologist this calendar year under Better Access?	

Referral Information

Which stream of support do you believe this person will be eligible for?

Reason for referral and mental health history:

Assessments

Please indicate the score of any assessments undertaken:

Kessler Psychological Distress Scale (K10+)
Kessler 5 Psychological Distress Scale (K5 - for Aboriginal and Torres Strait Islander people)
Short Form Survey (SF-12)
Health of the Nation Outcome Scale (HoNOS)
Patient Health Questionnaire (PHQ-9)
General Anxiety Disorder-7 (GAD-7)
Suicidal Ideation Attributes Scale (SIDAS)
Strengths and Difficulties Questionnaire (SDQ)
Other

GP Mental Health Treatment Plan

Please attach, or copy and paste below, patient's Mental Health Treatment Plan (if applicable)