|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **To Be Eligible The Client Must Meet All Three Criteria Below** | | | | | | | | | | | | | | | |
| 1. *Must be financially disadvantaged (e.g. Health Care Card or unemployed) or not have access to alternative care* | | | | 1. *Experiencing a mild to moderate mental health illness* | | | | | | | 1. *Currently not in crisis or in need of urgent assistance* | | | | |
| ***A GP MENTAL HEALTH CARE PLAN IS NOT REQUIRED FOR THIS PROGRAM*** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Client Details** | | | | | | | | | | | | | | | |
| Pension Card / HCC No: | | | | | Client Address: | | | | | | | | | | |
| NDIS Participant: | 🞏 Yes | | 🞏 No | |
| Client Surname: | | | | |
| Client First Name: | | | | |
| D.O.B: | | | | |
| 🕿: | | | | |
| Parent/Guardian Name (if under 16) or NoK: | | | | | | | | | | Ph: | | | | | |
|  | | | | | | | | | | | | | | | |
| **IMPORTANT: Please complete the following questions** | | | | | | | | | | | | | | | |
| Do you identify as: | 🞏 Aboriginal | 🞏 Torres Strait Islander | | | | | 🞏 Both | | | | | 🞏 Neither | | | |
| Gender: | 🞏 Male | 🞏 Female | | | | | 🞏 X (Indeterminate/Intersex/Unspecified) | | | | | | | | |
| Type of employment? | 🞏 Unemployed | 🞏 Full-time | | | | | 🞏 Part-time | | | | | | 🞏 Not in Labour Force | | |
| Homelessness? | 🞏 No | 🞏 Short-term emergency | | | | | 🞏 Sleeping rough | | | | | | | | |
| Perinatal? | 🞏 Yes | 🞏 No | | | | | | | | | | | | | |
| Marital Status? | 🞏 Widowed | 🞏 Married/defacto | | | | | 🞏 Never Married | | | | | | 🞏 Divorced/Separated | | |
| Country of Birth? | | | | | | | | | | | | | | | |
| Main language spoken at home? | | 🞏 English only | | | | 🞏Other – please state: | | | | | | | | | |
| How well does this person speak English? | | 🞏 Very Well | | | | 🞏 Well | | | 🞏 Not Well | | | 🞏 Not at all | | | |
|  | | | | | | | | | | | | | | | |
| **Referrer Details** | | | | | | | | | | | | | | | |
| Name: | | | | | | | | Ph: | | | | | | | |
| Practice/Organisation: | | | | | | | | Fax: | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Reason for Referral** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Mental Health Diagnosis / History** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Current Medications / Significant Health History / Diagnosis** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **K10 +** | | | | | | | | | **None of the time** | **A little of the time** | | **Some of the time** | | **Most of the time** | **All of the Time** |
| 1. In the last four weeks, about how often did you feel tired out for no good reason? | | | | | | | | | 1 | 2 | | 3 | | 4 | 5 |
| 1. In the last four weeks, about how often did you feel nervous? | | | | | | | | | 1 | 2 | | 3 | | 4 | 5 |
| 1. In the last four weeks, about how often did you feel so nervous that nothing could calm you down? | | | | | | | | | 1 | 2 | | 3 | | 4 | 5 |
| 1. In the last four weeks, about how often did you feel hopeless? | | | | | | | | | 1 | 2 | | 3 | | 4 | 5 |
| 1. In the last four weeks, about how often did you feel restless or fidgety? | | | | | | | | | 1 | 2 | | 3 | | 4 | 5 |
| 1. In the last four weeks, about how often did you feel so restless you could not sit still? | | | | | | | | | 1 | 2 | | 3 | | 4 | 5 |
| 1. In the last four weeks, about how often did you feel depressed? | | | | | | | | | 1 | 2 | | 3 | | 4 | 5 |
| 1. In the last four weeks, about how often did you feel that everything was an effort? | | | | | | | | | 1 | 2 | | 3 | | 4 | 5 |
| 1. In the last four weeks, about how often did you feel so sad that nothing could cheer you up? | | | | | | | | | 1 | 2 | | 3 | | 4 | 5 |
| 1. In the last four weeks, about how often did you feel worthless? | | | | | | | | | 1 | 2 | | 3 | | 4 | 5 |
| **TOTAL OUT OF 50** | | | | | | | | |  | | | | | | |
|  | | | | | | | | | | | | | | | |
| The next few questions are about how these feelings have affected you in the last four weeks. You need not answer these questions if you answered **“NONE OF THE TIME”** to all of the ten questions about your feelings. | | | | | | | | | | | | | | | |
| 1. In the last four weeks, how many days were you TOTALLY UNABLE to work, study or manage your day to day activities because of these feelings? | | | | | | | | | | | | | |  | |
| 1. [Aside from those days], in the last four weeks, HOW MANY DAYS were you ABLE to work, study or manage your day to day activities but had to CUT DOWN on what you did because of these feelings? | | | | | | | | | | | | | |  | |
| 1. In the last four weeks, how times have you seen a doctor or any other health professional about these feelings? | | | | | | | | | | | | | |  | |
| 1. In the last four weeks, how often have physical health problems been the main cause of these feelings? | | | | | | | | | 1 | 2 | | 3 | | 4 | 5 |
|  | | | | | | | | |  | | | | | | |
| **Consent** | | | | | | | | | | | | | | | |
| 🞏 I have discussed this referral with the client and the client consents to being referred to GP down south  Mental Health Service. | | | | | | | | | | | | | | | |
| Referrer Signature: | | | | | | | | | Date: | | | | | | |
| **PLEASE PROVIDE YOUR CLIENT A COPY OF THIS REFERRAL** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Please FAX this referral form to GP down south on: 08 9754 2985**  **or for enquiries**  **please contact the GP down south Mental Health Service on PH: 08 9754 3662** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Information for Client** | | | | | | | | | | | | | | | |
| **GP down south will contact you to book your assessment appointment.**  **If you have not had contact within 14 days, please contact the**  **GP down south Mental Health Service on PH: 08 9754 3662** | | | | | | | | | | | | | | | |