HUNTER NEW ENGLAND LOCAL HEALTH DISTRICT

Facility: Mental Health Line

MENTAL HEALTH SERVICE REFERRAL

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

HNEMR326T

HNE017040

Mental Health Telephone Access Line HNELHD - Phone: 1800 011 511
Return completed referral via Fax to 02 4923 6537 or Email to HNELHD-MHCC@health.nsw.gov.au

NOTE – If immediate response required, referrer to contact emergency services or advise client to attend nearest emergency department

Referral Date	Referral Time

Patient Information

Phone	Medicare Number ☐☐☐☐☐☐☐☐☐☐ Valid to ☐☐/☐☐☐☐

Indigenous Status: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Declined to respond

Preferred Language	Interpreter Required: ☐ Y ☐ N
Family Name	Given Name
DOB _____ /_____ / _____	☐ Male ☐ Female

Address

Emergency Contact Name	Relationship	Phone

Referrer Details

Name

Address

Phone	Fax	Email

Presenting problems/Reason for referral: Include current mental state, relevant medical & family history

What treatment has already been tried? ***'including psychological therapies and counselling'?***

HUNTER NEW ENGLAND MENTAL HEALTH SERVICE REFERRAL

Correspondence

BINDING MARGIN – DO NOT WRITE

201119

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Current Treatments (add additional pages as appropriate)

Medications (use generic - include any complementary/alternative medicines reported)	**Dose/frequency/route**	**Comments** eg prescriber, side effects, adherence

Risk Factors: Suicide or Homicide (thoughts, plans, intent, or behaviour), Violence, Vulnerability/harm from others, Absconding, Risk to children under 18 years

Has a safety plan been developed? ☐ **Y** ☐ **N**

Substance Use: current/historical (e.g. past and current substance use, amounts and frequency, features of dependence and abuse, prior treatments and their outcomes)

Children involved: ☐ **Y** ☐ **N** (add additional pages as appropriate)

Name (First name & surname)	**Relationship**	**Age/Date of birth**	**Current whereabouts**

Has a FACS notification been completed? ☐ **Y** ☐ **N**

Print Name	Designation	Signature	Date

BINDING MARGIN – DO NOT WRITE

 TRIAL DATES COMMENCED 01/2024 COMPLETED 06/2024 For trial feedback contact – Kate Simpson HNELHD-MHCC@health.nsw.gov.au