CANNONVALE F: (07) 4967 6799
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NORTHERN AUSTRALIA PRIMARY HEALTH LIMITED
A healthier future for all Australians

OFFICE HOURS Monday to Friday 8.30am – 4.30pm
ReferralsMHcvale@naphl.com.au
ReferralsMHmky@naphl.com.au
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This Mental Health Program is supported by funding from the Australian Government under the PHN Program.

Referral Form
Mental Health 12 Years and Over

If you consider this referral a high priority please call our office after faxing the referral

Eligibility

This person is financially disadvantaged? *(judgement made by GP)* Yes ☐ No ☐

This person has a current Mental Health Treatment Plan Yes ☐ No ☐

This person has attended less than 12 ATAPS or 10 Better Access sessions in the current calendar year Yes ☐ No ☐

Referral Date:

Persons Details

First Name | Surname

DOB | Gender

Address | Postcode

Phone (work) | Phone (home) | Mobile

Indigenous Status | Interpreter Required Yes ☐ No ☐

Medicare Card # | Ref # | Expiry | Health Care Card # | Expiry

Applicable Private Health Insurance? Yes ☐ No ☐

Contacts (Complete relevant field/s)

Can we contact these people if we are unable to contact the referred person to schedule an appointment Yes ☐ No ☐

Next of Kin/ Emergency Contact:

Name | Phone

Address | Postcode

Relationship to person:

Carer Details: (if applicable)

Name | Phone

Referrer Details (if applicable)

Name

Organisation

Address | Postcode

Fax | Provider Number

Referral Information

Reason for Referral

Diagnosis

Allergies

Current Medications (Please attach medications summary)

Relevant medical history/conditions (Please attach health summary)

Reason for Referral

☐ Depression ☐ Phobic Disorder ☐ Panic Disorder ☐ Mixed Anxiety & Depression

☐ Unexplained Somatic Complaints ☐ Sexual Disorders ☐ Generalised Anxiety ☐ Adjustment Disorder

☐ Peri-Natal Depression ☐ Sleep Problems ☐ Bereavement

K10 or EPNDS Score:

Medication

Is Patient Receiving Psychotropic Medication: Yes ☐ No ☐

If yes please indicate

☐ Benzodiazepines and anxiolytics ☐ Phenothiazines and/or Major Tranquillisers

☐ Antidepressants (SSRIs, SNRIs) ☐ Mood Stabilisers

Consent to referral:

I have discussed this referral with the person and/or their guardian and am satisfied that the person and/or their guardian understands a able to provide informed consent to this referral

Referrer's signature: _____

Please attach GP Mental Health Treatment Plan (MHTP), Medication Summary and Health Summary