# North East Valley Division of General Practice

## Parent and Infants Mental Health Program Referral

### GP/Psychiatrist details:

| | |
|---|---|
| Name: | Practice: |
| Provider No: | Address:<br>Suburb: |
| Tel: | Date: |

### Patient details:

| | |
|---|---|
| Name: | DOB: |
| Address: | City/Suburb: Postcode: |
| Tel/Mobile: | Baby's name: |
| Medicare Number: | Baby's DOB: |

**Risk** (to self/others, including suicidal ideation/intent, previous attempts). Diagnosed mental disorder (please specify):

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|---|
| |

### The following checklist will ensure the patient meets eligibility criteria for this service: (please indicate Y or N)

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|---|---|---|---|
| 1. Diagnosed disorder causes significant disablement? | | 4. The GP/Psychiatrist is principally responsible for this patient's clinical mental health care. | |
| 2. The patient has been hospitalised or is at risk of hospitalisation? | | 5. Does the patient have a Mental Health Care Plan in place (item 2710)? | |
| 3. The person will require continuing treatment/management over prolonged period? | | 6. Does the patient give consent to treatment from a mental health nurse? | |

7. Estimated level of need for mental health disorder: High ☐ Medium ☐ Low ☐

### Details of service providers:

| | |
|---|---|
| Name: | MCHN |
| Name: | Organisation: |

### Please Note:

1. Please attach any previous discharge summaries, the mental health care plan and/or a referral letter.
2. If there are other current service providers please ensure that they are aware of the referral to this program.

**PLEASE RETURN THIS FORM TO ROSEMARY LALOR TOGETHER WITH A COPY OF THE 2710 TO FAX NUMBER 9404 5278**