



Integrated Primary Mental Health Care Program

REFERRAL FORM – to be completed by Health Practitioner

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
2. Experiencing a mild to moderate mental health illness
3. Currently not in crisis or in need of urgent assistance

Please attach a Mental Health Care Plan with this referral form

REFERRAL WILL NOT BE ACCEPTED IF ALL INFORMATION IS NOT COMPLETED

Client Details

Surname: _____ First Name: _____ DOB: ____ / ____ / ____
 Phone: _____ Email: _____
 Address: _____
 Postal Address (if different from above): _____
 Parent/Guardian Name (if under 16): _____
 Phone: _____ Signature: _____
 Next of Kin: _____ Phone: _____
 Pension Card/HCC No: _____ NDIS Participant: Yes No
 Court Order: Yes No COVID-19 Vaccination Status: 1st Dose 2nd Dose Booster

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
 Source of Income: _____ Mental Health Care Plan: Yes No
 Homelessness: No Short-term Emergency Sleeping Rough
 Marital Status: Widowed Married/Defacto Never Married Divorced/Separated
 Country of Birth: _____ Perinatal: Yes No
 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
 Has access to telehealth: Yes No (please provide email for TEAMS invite) _____

Referrer Details

Name: _____ Phone: _____ Fax: _____
 Practice/Organisation: _____
 Address: _____
 Date: _____ Any other agencies involved: _____

Reason for Referral

Please continue to next page

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?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
2. In the last four weeks, about how often did you feel nervous?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
3. In the last four weeks, about how often did you feel so nervous that nothing could calm you down?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
4. In the last four weeks, about how often did you feel hopeless?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
5. In the last four weeks, about how often did you feel restless or fidgety?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
6. In the last four weeks, about how often did you feel so restless you could not sit still?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
7. In the last four weeks, about how often did you feel depressed?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
8. In the last four weeks, about how often did you feel that everything was an effort?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
9. In the last four weeks, about how often did you feel so sad that nothing could cheer you up?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
10. In the last four weeks, about how often did you feel worthless?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 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.

11. 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?					
12. [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?					
13. In the last four weeks, how times have you seen a doctor or any other health professional about these feelings?					
14. In the last four weeks, how often have physical health problems been the main cause of these feelings?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Consent

I have discussed this referral with the client and the client consents to being referred to Amity Health Mental Health Portal

Referrer Signature: _____ Date: _____

PLEASE PROVIDE YOUR CLIENT A COPY OF THIS REFERRAL

Please return this completed form and any other relevant documentation to Amity Health via one of the following methods:

Fax: 08 9842 2798

Email: query@amityhealth.com.au

For enquiries please contact the Amity Health Mental Health Portal on 08 9842 2797

Information for Client

Amity Health will contact you via phone. Please contact Amity Health on 08 9842 2797 to book an appointment if you have not heard from us in 7days.

Head Office: 136 Lockyer Avenue Albany WA 6330 | PO Box 5294 Albany WA 6332

Wheatbelt Offices: Merredin, Moora, Narrogin, Northam South-East Coastal Goldfields Office : Esperance