COUNSELLING SERVICES REFERRAL FORM

Please sign and submit the completed referral form via fax to: **(08) 9242 1584**
or email to **counselling@blackswanhealth.com.au**
*please note that the mental health care plan has to be completed and billed to Medicare

BLACK SWAN HEALTH LTD

Incomplete referral form may result in processing delays and impact on the patient's care coordination
Please refer to the Black Swan Health website for Program Guidelines, eligibility and exclusion criteria

REFERRAL REQUIRED (please select one of the two options below)
☐ Individual counselling sessions
☐ Group counselling session (specify group name if known:_____)

BINDING MARGIN – NO WRITING

Date of referral:____/____/_____ Medicare Number: _____

1. PATIENT DETAILS

Title:_____ ☐ Male ☐ Female ☐ Other D.O.B.:____/____/ _____

Last Name: _____ First name(s): _____

Address:_____ Suburb:_____ Postcode: _____

Mobile:_____ Home: _____ Email: _____

Language spoken at home: _____ Is an interpreter required? ☐ Yes ☐ No

How well does the patient speak English?
☐ Very well ☐ Well ☐ Not Well ☐ Not at all ☐ Unknown

Please tick if applies ☐ Health Care Card/Centrelink Concession/Pensioner

Emergency / Carer / Next of Kin Name:_____ Phone:_____

Is the patient of Aboriginal and/or Torres Strait Islander descent? ☐ Yes ☐ No

2. OTHER PROVIDERS DETAILS

Other providers involved in patient's care (eg: psychologist, psychiatrist, social worker, other GP, case manager or accommodation)

Role	Name	Address	Contact details

3. REFERRAL DETAILS

GP's name: _____ **GP Stamp**

GP's practice:_____

Address:_____

Suburb:_____ Postcode:_____

Phone:_____ Fax: _____

Email:_____

GP Provider No: (must complete)

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4. GP MENTAL HEALTH TREATMENT PLAN (MBS Items 2700, 2701, 2715 or 2717)

Presenting Issues (patient's current mental health issues including recent stressors, current domestic and social circumstances, eg: relationships and occupation. For PND referrals only, please note due date and actual date)
Details:

Mental health history Has the patient ever received specialist mental health care? ☐ Yes ☐ No
(relevant biological, psychological, substance abuse, social, medical, physical and family history including suicidal behaviour)
Details:

Medications (attach information if required) Is the patient receiving psychotropic medication? ☐ Yes ☐ No
Details:

History of criminal charges? ☐ Yes ☐ No
Details:

Current or pending charges / issues? ☐ Yes ☐ No
Details:

Results of mental health examination (record after patient has been examined and consider the appropriateness of Mini Mental State Examination for patients over 75 years or if otherwise indicated)

Appearance	
Cognition	
Thought process	
Thought content	
Attention	
Memory	
Insight	
Behaviour	
Speech	
Mood and affect	
Perception	
Judgement	
Orientation	
Other/s (specify)	

Risk Assessment	Ideation / thoughts	Intent	Plan
Suicide			
Self-harm			
Harm to others			
Further details on any identified risk/s:			

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Outcome tool used (except where clinically inappropriate – include date of assessment and results)
Details:

Please tick diagnosis(es) as appropriate

- ☐ ADD / ADHD
- ☐ Adjustment disorder
- ☐ Alcohol Use Disorder
- ☐ Anxiety
- ☐ Bereavement
- ☐ Bipolar
- ☐ Conduct disorder
- ☐ Depression
- ☐ Dissociative disorder
- ☐ Drug Use Disorder
- ☐ Eating disorders
- ☐ Mental disorder NOS
- ☐ Mixed Anxiety & Depression
- ☐ Neurasthenia
- ☐ Panic disorder
- ☐ Perinatal Depression
- ☐ Phobic disorder
- ☐ Sexual disorder
- ☐ Unexplained Somatic Complaints
- ☐ Other (please specify): _____

Additional child-specific disorders only

- ☐ Attachment disorders
- ☐ Chronic fatigue syndrome
- ☐ Disruptive disorder NOS
- ☐ Elective/selective mutism
- ☐ Emotional disorders
- ☐ Enuresis/encopresis
- ☐ Feeding disorders
- ☐ Oppositional Defiant Disorder
- ☐ Separation Anxiety
- ☐ Somatoform disorders
- ☐ Substance use
- ☐ Tic disorders

Contextual Factors including:

- ☐ Problems relating to upbringing or family circumstances
- ☐ Problems with negative life events

Patient's goals (record the mental health goals agreed by the patient and GP and any actions the patient will need to take)
Details:

Required Focussed Psychological Interventions (treatments, actions and support services to achieve patient's goals)

General / ATSI / PND Counselling Services

- ☐ Cognitive Behavioural Therapy
- ☐ Psycho-education
- ☐ Interpersonal Therapy
- ☐ Narrative Therapy
- ☐ Skills training or relaxation strategies
- ☐ As determined by Allied Mental Health clinician

Counselling services for children

- ☐ Further assessment
- ☐ Behavioural interventions
- ☐ Parenting/family based interventions
- ☐ Cognitive behavioural interventions
- ☐ As determined by Allied Mental Health clinician

Referral Consent

GP Consent

I_____ (GP name) have discussed the assessment with my patient, including all aspects of the plan and the agreed date for review as (insert date DD/MM/YY) / / and my patient has agreed for a referral to Black Swan Health.

Signature _____ Date _____

Patient Consent

I_____(patient name) have been explained all aspects of my care plan and agreed on the proposed review date. I also agreed to my referral to Black Swan Health and my health information being shared with Black Swan Health.

Signature _____ Date _____

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