

Low Intensity Mental Health Support Group Referral



TeamHEALTH actively promotes and supports an inclusive and diverse culture. We welcome all people, regardless of age, gender, race, ability, sexual orientation, faith, religion and all other identities represented in our community.

Participant Details

Participant's Name	_____	Preferred Name	_____
Date of Birth	_____	Gender	_____
Email Address	_____	Phone Number	_____
Address	_____		
Country of Birth	_____	Language at Home	_____
Origin	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Non-Indigenous <input type="checkbox"/> Not Stated		
Interpreter Required?	<input type="checkbox"/> No <input type="checkbox"/> Yes		

Referral Details

Current Mental Health Concern and/or Diagnosis:

LIMHS Group:

- | | |
|---|--|
| <input type="checkbox"/> Rapid Creatives | <input type="checkbox"/> Black Cockatoos |
| <input type="checkbox"/> Darwin Community Group | <input type="checkbox"/> The Green Thumbs |
| <input type="checkbox"/> The Mindful Reset | <input type="checkbox"/> Katherine Community Group |

Person Referring	_____
Relationship to Participant	_____
Contact Details	_____
Referrer's Signature	_____
	Date _____

Consent

Northern Territory Primary Health Network (PHN) is the funder of this service and uses de-identified information for future planning of mental health services across the Northern Territory, as well as for quality improvement and monitoring service delivery.

If you provide consent, your personal information will be de-identified and shared with Northern Territory PHN. This de-identified information includes information such as your gender, date of birth, and the types of services you receive. De-identified information does not include your name, your address, or your Medicare number. To ensure your privacy is protected, only Northern Territory PHN staff who are authorised to see the de-identified information will be able to do so.

If you refuse consent, we will still provide this service to you. Your information will not be given to Northern Territory PHN.

<div>_____</div>	<div>_____</div>	<div>_____</div>
Signature of Participant	Signature of Public Guardian (if applicable)	Date

In the absence of written consent, verbal consent was gained ☐ No ☐ Yes

Risk Assessment (Referrer to complete)

Participant risk factors (referrer to complete)	Yes	No
History of suicide attempt/s or current suicide ideation	<input type="checkbox"/>	<input type="checkbox"/>
Recent traumatic life event	<input type="checkbox"/>	<input type="checkbox"/>
Current misuse of drugs or alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Forensic history	<input type="checkbox"/>	<input type="checkbox"/>
Recent incident involving aggression/violence	<input type="checkbox"/>	<input type="checkbox"/>
Known use of weapons	<input type="checkbox"/>	<input type="checkbox"/>
Expressing intent to harm others	<input type="checkbox"/>	<input type="checkbox"/>
Preoccupation/hallucinations with violent or paranoid themes/ideas	<input type="checkbox"/>	<input type="checkbox"/>
Inappropriate sexual behaviour	<input type="checkbox"/>	<input type="checkbox"/>
Reduced ability to self-control / self-regulate	<input type="checkbox"/>	<input type="checkbox"/>
Major physical disability/illness (including infectious disease)	<input type="checkbox"/>	<input type="checkbox"/>
Known prejudices – ethnic, religions, other:	<input type="checkbox"/>	<input type="checkbox"/>
Issues with compliance eg appointments, medication. If yes, please detail:	<input type="checkbox"/>	<input type="checkbox"/>

Protective factors

Other identified risks

Completing this Form

- Please call TeamHEALTH on 1300 780 081 if you need any assistance completing this form.
- Send the completed form to: AdultSupportsReferrals@teamhealth.asn.au
- We will respond to referrals within 24 hours or next business day to arrange an assessment.

Thank you for your referral