GP Access Referral Form

Please ensure all pages (including risk assessment on page 3) are completed then fax or send to the Southern or Western Office.

GP Access South
UnitingSA
PO Box 288, Goodwood 5034
Fax: 8357 9565
Phone: 8357 9030

GP Access West
UnitingSA
PO Box 3032, Port Adelaide 5015
Fax: 8241 2831
Phone: 8440 2217

Patient Name: **Address:** **Phone:** **Date of Birth:**	**GP Name:** **Practice Details:** **Phone:** **Date of Assessment:**
Primary Reason for Referral:	
Primary DSM-IV Diagnosis:	
Assessment Tool (i.e. K10, DASS)	Score:
Presenting Concerns:	
Family History: **Family History of Mental Health Issues:**	**Personal History (educational, relationships, social etc.):**
Current Medications: **Tobacco, Alcohol and/or other Substance Use:**	

Abuse History (i.e. Physical, Sexual, Domestic Violence)

1. What support needs does the patient have and what are the requested goals for support? (Please tick appropriate boxes)

- ❑ Accommodation - *Support to find and establish suitable accommodation.*
- ❑ Social Needs - *Support to develop and maintain social networks & assistance with family/personal relationships.*
- ❑ Independent Living - *Support that assists clients to develop skills and take responsibility for such things as shopping, cooking, cleaning, self-care, using public transport etc.*
- ❑ Community Links - *Support to participate in meaningful daytime activities such as community groups, education, training, work, sport etc.*
- ❑ Health Issues - *Support that enables clients to take responsibility for their physical & mental health. (e.g. gathering information about their health conditions, attending follow-up appointments, engagement with other health service providers)*
- ❑ Finances - *Support to develop skills and confidence in regards to budgeting, bill paying, and associated financial matters (e.g. Centrelink Payments and ensuring clients receive their full entitlements/payments.).*

2. Please provide more specific information regarding the patients support needs and goals, and what benefits are anticipated from engaging in support.

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3. What other services/agencies are currently involved in support.

Please specify: ………………………………………………………………………………………….

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4. Has the person previously received support from G.P. Access: Yes ❑ No ❑

5. Are there any know safety issues to consider when conducting home visits (e.g., living with a violent family member/other)? Yes ❑ No ❑

If Yes, Please Specify…………………………………………………………………………..

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6. Crisis Management: Next of kin, Carer or person to contact in case of a crisis:

Name: ………………………………………………………. Relationship: ……………………

Address: ………………………………………………………. Telephone: ……………………..

GP and patient's agreed crisis management strategies:

(Role of the GP, how should a Community Support Worker respond, which services and people to contact)

a)……………………………………………………………………………………………………….

b)……………………………………………………………………………………………………….

c)……………………………………………………………………………………………………….

d)……………………………………………………………………………………………………….

If the patient has children in their care, is there a plan or nominated Carer for the children in a crisis situation: (if yes, please describe above) ❑Y ❑N

Referring Doctor's signature: .... **Date: …/…/…**

Patient's signature: .... **Date: …/…/…**

RISK ASSESSMENT (*Please tick appropriate Box for each domain*).		
RISK OF HARM TO SELF (1)	❑0. None **(No thoughts or action of harm)**	❑1. Low **(Fleeting suicidal thoughts but no plans/current low alcohol or drug use**
❑2. Moderate **(current thoughts/ distress/ past actions without intent or plans/ moderate alcohol or drug use)**	❑3. Significant **(current thoughts/past impulsive actions/recent impulsivity/some plans, but not well developed/increased alcohol or drug use)**	❑4. Extreme **(current thoughts with expressed intentions/past history/plans/unstable mental illness/high alcohol or drug use, intoxicated/violent to self/means at hand for harm to self)**
RISK OF HARM TO OTHERS (2)	❑0. None **(No thoughts or action of harm)**	❑1. Low **(Fleeting "harm to others" thoughts but no plans/current low alcohol or drug use)**
↓ 2. Moderate **(current thoughts/ distress/ past actions without intent or plans/ moderate alcohol**	❑3. Significant **(current thoughts/past impulsive actions/recent impulsivity/some plans, but not well developed/increased alcohol or drug use)**	❑4. Extreme **(current thoughts with expressed intentions/past history/plans/unstable mental illness/high alcohol or drug use, intoxicated/violent to others/means at hand for harm to others)**
LEVEL OF PROBLEM WITH FUNCTIONING (3)	❑0. None/Mild **(no more than everyday problems/slight impairment when distressed)**	❑1. Moderate **(Moderate difficulty in social/occupational or school functioning/reduced ability to cope unassisted)**
❑2. Significant impairment in one area **(either social, occupational or school functioning)**	❑3. Serious impairment in several areas **(social, occupational or school functioning) l or drug use)**	❑4. Extreme Impairment **(inability to function in almost all areas)**
LEVEL OF SUPPORT AVAILABLE (4)	❑0. No problems/Highly Supportive **(all aspects/most aspects highly supportive/ self/family/professional/ effective involvement)**	❑1. Moderately Supportive **(variety of support available, able to help in times of need)**
❑2. Limited Support **(few sources of help, support system has incomplete ability to participate in treatment)**	❑3. Minimal **(few sources of support and not motivated)**	❑4. No support in all areas
HISTORY OF RESPONSE TO TREATMENT (5)	❑0. No problem/minimal difficulties **(most forms of treatment have been successful/new client)**	❑1. Moderate response **(some responses in the medium term to highly structured interventions)**
❑2. Poor response **(responds only in the short term with highly structured interventions)**	❑3. Minimal response **(minimal response even in highly structured interventions)**	❑4. No response **(no response to any treatment in the past)**
ATTITUDE AND ENGAGEMENT TO TREATMENT (6)	❑0. No problem/Very Constructive **(accepts illness and agrees with treatment/new client)**	❑1. Moderate response **(variable/ambivalent response to treatment)**
❑2. Poor engagement **(rarely accepts diagnosis)**	❑3. Minimal response **(client never co-operates willingly)**	❑4. No response **(client has only been able to be treated in an involuntary capacity)**
OVERALL ASSESSMENT OF RISK **LOW** ↓ **MEDIUM** ↓ **HIGH** ↓ **EXTREME** ↓		

ADDITIONAL INFORMATION ASSOCIATED WITH RISK:
RISK MANAGEMENT/SAFETY PLAN: