UNITING SA Together we can

GP Access Referral Form

Please ensure all pages (including risk assessment) are completed, then fax or send to:

UnitingSA, GP Access
Postal address: 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)	

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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.**

………

………

………

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

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

………

4. **Has the person previously received support from GP 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……………………………………………………………………………..

………..

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)………

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