PTS SEEK OUT SUPPORT (SOS) Referral Form





This referral is only valid with a PTS Referral Code, obtained from Nepean Blue Mountains PHN. Phone: 1800 223 365 Psychological Therapy Services (PTS) dedicated referral line

SOS REFERRAL CODE:		DATE OF REFERRAL:	
AHP name:		AHP fax/phone:	
GP DETAILS			
Name:		Practice name:	
Practice phone:		Practice fax:	
PATIENT DETAILS			
Name:		DOB:	
Healthcare card number:	□ N/A	Phone:	
Mental health diagnosis:			
Medication/s:			
KEY SUPPORTS: Patient has given consent for GP/Provider to contact support person: ☐ Yes ☐ No			
Name:		Phone:	
Relationship to patient:			
OTHER MENTAL HEALTH PROFESSIONALS CURRENTLY INVOLVED (e.g. psychiatrist, social worker)			
Name:		Phone:	
Name:		Phone:	
Recommendation at the conclusion of PTS SOS sessions			
☐ GP review not required. Patient is seeking further referral through Medicare Better Access to Psychiatrists, Psychologists, and General Practitioners. Mental Health Treatment Plan must be attached.			
NB: Allied Health Professionals are entirely responsible for ensuring that appropriate MBS item(s) are billed. http://www.mbsonline.gov.au/			
☐ GP review required. Patient to return to GP for review.			
REASON FOR REFERRAL			
KEY RISKS IDENTIFIED / RECENT STRESSORS			
ADDITIONAL REFERRAL NOTES			

Patient Consent: By consenting to this referral, I understand that all information in this referral, and any previous referrals (where applicable) including my personal information, will be collected for the <u>primary purpose</u> of delivering care; and for the ongoing monitoring, reporting, evaluation and improvement of services. I consent with the understanding that this information will only be used, disclosed and stored for its primary purpose, between my health service provider(s), the Department of Health, and the Nepean Blue Mountains Primary Health Network (NBMPHN) and affiliated partner organisation(s)*, in accordance with the *Australian Government Privacy Act, 1988*.

* Affiliated partner organisation(s) means those required to support the monitoring, reporting, evaluation and/or clinical governance for the service.

Patient Signature:	Date:
Consent for children and young people:	
Parent/Guardian/Carer Name:	
Contact number:	Email:
Signature	Date
Referral Requirements:	
For people at low to moderate risk of suicide or self-available.	harm the NBMPHN Seek Out Support (SOS) service is
Patients are eligible to receive 7 sessions over a three-n	nonth period.
SOS eligibility:	
☐ Patients over the age of 14	
☐ Patients who, after a suicide attempt or self-harm inci hospital, or released into the care of a GP from an Accid	<u> </u>
☐ Patients who have presented to GP after an incident	of self-harm
☐ Patients who have expressed thoughts of suicide or s	elf-harm to their GP, friends or family
$\hfill\Box$ The SOS Service may also provide support to those firsk in the aftermath of a suicide.	amily members or carers who are considered at increased
The SOS Service is not designed to support Patients who These Patients should be referred without delay to the A	no are at acute and immediate risk of suicide or self-harm: ACCESS Team (acute mental health team).
The service is not designed for Patients who are consider	ered to be high risk of suicide or self harm
The service is not designed for Patients who are receiving health services or Patients who present with long lasting	

24 hour mental health referral 24 hour telephone and 24 hour support: Lifeline 7 days a week for people who need help finding triage service staffed by online counselling support provides suicide prevention mental health professionals to people affected by the right mental health services to people thoughts of suicide or selfexperiencing a personal services. harm crisis.

Suicide Call Back Service

1300 659 467

Alternative/crisis support:

Mental Health Access Line

1800 011 511

Lifeline

13 11 14

Head to Health 1800 595 212