Telepsychiatry Referral Form

This referral is only valid with a unique referral code obtained from the Wentworth Healthcare intake line.
To obtain a referral code, GPs, Nurse Practitioners and Paediatricians must contact the Intake team on 1800 223 365.

For queries related to telepsychiatry appointments or wait times, please contact Dokotela directly on (02) 8003 7668.

UNIQUE REFERRAL CODE:	**DATE OF REFERRAL:**	
GP DETAILS		
Name:	Provider number:	
Practice phone:	Practice fax:	
HealthLink EDI or Practice email address:		
PATIENT DETAILS		
Name:	DOB:	
Phone:	Home phone:	
Address:		
Healthcare card number:	Expiry date:	
Medicare number:	Ref #	Expiry date:
Primary mental health diagnosis:		
Aboriginal and Torres Strait Islander Status: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Not disclosed ☐ Neither Aboriginal nor Torres Strait Islander		
Current Medication/Treatment: ☐ Antipsychotics ☐ Anxiolytics ☐ Antidepressants ☐ Hypnotics and Sedatives ☐ Psychostimulants and Nootropics		
Has the patient experienced a recent history of self-harm, suicide attempt or were thoughts of suicide or self-harm a factor in obtaining this referral ☐ Yes ☐ No		
Labour force participation: ☐ Employed ☐ Unemployed/looking for work ☐ Not in the Labour Force ☐ Undisclosed		
Source of income: ☐ <16 years old ☐ Paid employment ☐ Disability Support ☐ Other pension ☐ Nil		
Relationship status: ☐ Married or De facto ☐ Never Married ☐ Widowed ☐ Divorced ☐ Separated		
Housing Status: ☐ Stable ☐ Short Term/Emergency ☐ Homeless/Sleeping Rough ☐ Undisclosed		
Consent to engage with current supports		
Primary Support Person (if applicable)		
Name:	Phone:	
Relationship to patient:	Consent to contact? ☐ Yes ☐ No	
Other support services involved in patient's care		

Type	Provider name and contact details	Consent to contact?
Psychological Therapy Services		

Mental Health Nurse Incentive program		
Private Psychologist or psychotherapist		
NDIS support coordination		
Psychosocial support service		
Homelessness service		
Drug and alcohol support services		
Other service(s)		

Presenting Issues / Reason for Referral (please ensure patient psychiatric history, medication summary and a referral letter are attached to the referral form):

CONSENT

I consent to my personal information being provided by Wentworth Healthcare, provider of the Nepean Blue Mountains Primary Health Network to the Department of Health and Aged Care, and state and territory health departments/agencies to be used for statistical and evaluation purposes designed to improve mental health services in Australia.

I understand that this will include details about me such as date of birth and gender but will not include my name, address or Medicare number. I understand this includes the use of personal information to generate a unique key, which can be used to link my de-identified data to other de-identified data to facilitate research.

I understand that my personal information will not be provided to the Department of Health and Aged Care or state and territory health departments/agencies if I do not give my consent.

I also understand that my consent is not required for the Department of Health and Aged Care and state and territory health departments/agencies to include data about my use of services, combined with information about other clients, in summary reports about the activities funded by Wentworth Healthcare, provider of the Nepean Blue Mountains Primary Care Network because these do not require personal information.

I understand that all information in this referral will be collected for the primary purpose of delivering care and for the ongoing monitoring, reporting, evaluation and improvement of services.

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 primary purpose 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: _____

Signature _____ **Date** _____

☐ **Patient, or guardian has given informed verbal consent on (date):** _____

GP STAMP OR SIGANTURE AND DATE

PLEASE ENSURE THE FOLLWED BEFORE SENDING TO DOKOTELA
☐ This referral form is complete ☐ A unique referral code has been obtained from WHL intake 1800 223 365 ☐ A current K-10 or K-5 (suitable for Aboriginal and Torres Strait Islander Peoples or, for children and adolescents between 4-17, a current, age-appropriate version of the SDQ has been completed and scores recorded or attached to this form. ☐ A referral letter to Dokotela Telepsychiatry Service has been attached ☐ Patient psychiatric and medication summary is attached

Please send completed referral form and attachments listed above to Dokotela Pty Ltd

HealthLink EDI: Dokotela

Fax: (02) 8569 1844

IMPORTANT REVISED REQUIREMENTS

- **If the patient does not engage with the program within three months of the referral date, the referral will be considered invalid and a new referral will be required for any future engagement.**
- **Incomplete referrals, including those that do not have a referral letter attached, will be declined.**
- **Please ensure the patient has been provided with the Dokotela program flyer and FAQ document to ensure they understand their responsibilities and what to expect from the program.**
- **Referrals for ADHD assessment or treatment are no longer covered by this program**