

Referral Code	Referring GP or Psychiatrist:
Referrer Post Code:	Date of Referral:
Mental Health Nurse:	Client Initials:
Client Post Code:	Client Date of Birth:

Client Demographic Data (required at 1 <sup>st</sup> session only)		
<b>1. Main Language spoken at home:</b> <input type="checkbox"/> English <input type="checkbox"/> Other (Specify): How well does client speak English?		<b>2. Aboriginal or Torres St Islander status</b>
<b>3. Country of birth:</b>		<b>4. Gender</b>
<b>5. Marital status:</b>		<b>6. Labour Force status:</b>
<b>7. Source of income:</b>		<b>8. Residential Status (4 weeks prior to the current referral):</b>
<b>9. Health Care Card:</b>	<b>10. Mental Health Treatment Plan:</b>	<b>11. NDIS Participant:</b>
<b>12. Principal diagnosis (Select one):</b>		
<b>13. Additional diagnosis (Select one):</b>		
<b>14. Medication:</b>		
<b>15. Has the individual had a recent history of suicide attempt or suicide risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>16. Disaster funding: Does the patient have high levels of distress resulting from either Bushfire or Flood?</b> <input type="checkbox"/> Bushfire <input type="checkbox"/> Flood <input type="checkbox"/> Both <input type="checkbox"/> Neither		

**As a minimum, all patients MUST have a K10+ or K5 (for Aboriginal and Torres Strait Islander consumers) reported at BOTH the start of each referral and again on discharge.**

<b>PRE and Post outcome tool</b>	
Measure Date	K10 Result:

Following first contact please return to:  
[mhnip@nbmphn.com.au](mailto:mhnip@nbmphn.com.au)