Mental Health Nurse Incentive Program Referral Form

Please contact 1800 223 365 to obtain referral code

Wentworth Healthcare
Blue Mountains | Hawkesbury | Lithgow | Penrith

Referral form and mental health treatment plan
to be sent directly to the Mental Health Nurse.

Referral Date	Patients initials	Year of Birth	M / F / Other	Postcode

MHNIP Referral Details:

Referral Code	Nurse Name	Phone	Fax / Email

Eligibility Criteria (The patient must meet all of the criteria to be eligible for MHNIP

Criteria 1*	Criteria 2*	Criteria 3*	Criteria 4*
☐ The patient has been diagnosed with an eligible mental health disorder: **List diagnosis:**	☐ The disorder causes significant disablement to the patients social personal and occupational functioning	☐ the patient is expected to require continuing treatment and management of their mental health disorder over the next two years	☐ The patient has experienced at least one episode of hospitalization for treatment of mental health disorder, or is at risk of requiring hospitalisation in the future if appropriate treatment and care is not provided

Additional information to support patient:

Does the patient speak a language other than English?

Does the patient live alone?

Has the patient received specialist mental health care before? Public, Private, Medical, Allied Health

Is the patient receiving medication? Benzodiazepines, Anti-Depressants, Antipsychotics, Mood Stabilisers

Is there a history of aggression (physical or verbal) towards health professionals? *(For safety assessment purposes. Will not affect acceptance of referral)*

Reason For Referral

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 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:

GP signature (provide GP Details or stamp):

phn NEPEAN BLUE MOUNTAINS
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