medicare Mental Health
1800 595 212

Connect to Wellbeing

Connect to Wellbeing Assessment and Referral Form

This service provides streamlined access to a range of **mental health services** across the Northern Territory. Upon review of the referral, the Connect to Wellbeing team will determine the right level and type of intervention in collaboration with the consumer including low intensity/early intervention strategies. The Initial Assessment and Referral Decision Support Tool (IAR-DST) is used to help explore and inform an individual's treatment needs.

Personal DETAILS					
Full Name:			Referral Date:		
DOB:		Gender:		☐ Aboriginal	☐ Torres Strait Islander
Country of birth		Main Language Spoken at Home:			
Phone:		Email:			
Address:					
Suburb:			Postcode*:		

Emergency Contact			
Name:		Phone:	
Relationship to Client:			

Does the individual have any of the following			
☐ Health Care Card	☐ NDIS participation	☐ DVA card	☐ None/unknown

If individual is experiencing financial hardship, please provide detail:
(For example, has recently lost employment or is experiencing domestic violence and is unable to access bank accounts).
Other services the individual is currently connected to:
Reason For Referral:

☐ Suicide Prevention Services
(For individuals who are experiencing a period of increased risk of suicide ie. after a recent suicide attempt, expressed strong suicidal ideation or are considered at risk in the aftermath of suicide)
Note: the individual/consumer will be contacted by COB the next business day and offered an appointment within 72 hrs of referral.

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An Australian Government Initiative

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Improving Mental Health and Wellbeing

REFERRER DETAILS			
Referrer name:		Referral Date:	
Organisation:			
Address:			
Phone:		Fax:	
Email:			

Consent to Collect and Share Information

Referrers must confirm that they **have read out the following/it has been read by** the individual and that the individual understands and has given informed consent in accordance with the Privacy Act 1988.

I give consent for Connect to Wellbeing to collect personal information about me, including sensitive health information, and sharing my personal information with the funder of this service, Northern Territory PHN. The funder uses this information for program management, quality improvement and monitoring service delivery. I also give consent for Connect to Wellbeing to seek and share information concerning matters related to this application, with my referrer, relevant Local Health District services, the emergency contact outlined in this form, and other service providers relevant to this referral, including my chosen service provider.

Yes ☐ (referral cannot proceed if this consent is not provided)

If I would like more information about Neami's Privacy Policy and Guidelines, I understand it is available on Neami's website (www.neaminational.org.au).

Individual's Signature
(or Guardian/Parent if a child) _____ Date _____

Or verbal consent Tick if applicable ☐

Referrer signature _____ Date _____

The referrer agrees that all information submitted in this referral is an accurate reflection of the applicant's support needs, is correct with no information withheld and is necessary for Connect to Wellbeing to fulfill its duty of care to consumers, staff and other partner agencies.

Appendix A – if no Mental Health Treatment Plan (MHTP) is available

If no MHTP is available, Appendix A may be used for individuals who meet one of the following:

- Suicide prevention
- Aboriginal and/or Torres Strait Islander
- Reside in a regional or remote location

Please note a MHTP is still required within four weeks of referral to Short Term Therapies. Health services, Allied Health professionals and community services can complete Appendix A

Outcome measures (please only fill out one):

SDQ score _____ K10 score _____ K5 score ____

Mental health diagnosis: (Diagnosis and symptoms if known. Or risk of developing mental illness if under 12 years old)	
Medication:	
Substance use:	
Relevant history: (Other relevant history/ factors such as climatic events, disabilities, medical conditions or difficulties with activities of daily living)	
Risk: (Describe if risk to self or others.)	
Care team: (Health professionals involved in person's care i.e. GP, psychiatrist.)	

Send this referral with a Mental Health Treatment Plan to:
Email: nt.connecttowellbeing@neaminational.org.au
Fax: 879062260