Referral Form

Adelaide and Country SA Medicare Mental Health phone service

medicare

Mental Health
1800 595 212

Servicing people in the Adelaide and Country SA PHN catchment areas. The Medicare Mental Health phone service provides a free, confidential referral service for anyone seeking help for their wellbeing or wanting support for a patient or someone they care about.

Please note, this is a not a crisis service. If the person has acute mental health needs, refer to Mental Health Triage or Emergency Triage Liason Service on 13 14 65.

Referrer Details

Referrer name _____ Role / Organisation _____

Address _____ Suburb _____ Postcode _____

Phone _____ Fax _____ *Email _____

*To receive notification that this referral has been allocated, email address is required

Consumer Details

Full name _____ Preferred name _____

DOB _____ Gender _____ Pronouns _____

Address _____ Postcode _____

○ No fixed address Mobile _____ Email _____

Interpreter required? ○ Yes - Language _____ ○ No

Preferred Referral Pathway to Medicare Mental Health (please advise yes or no).

Head to Health Intake, Assessment & Referral Service Agency ○ Yes ○ No

Head to Health Service Navigation for Eating Disorders ○ Yes ○ No

Risk Assessment: ○ Nil ○ Low ○ Moderate ○ High

(if high, please refer directly to mental health triage 13 14 65)

Consent to Share Information

The Privacy Act requires that the consumer sign this form to provide consent for the release of their information.
By signing below, the consumer gives consent for Medicare Mental Health to seek and share information concerning matters related to this application, with the Adelaide PHN/Country SA PHN, the referral support person outlined in this form, and other service providers relevant to this referral. The consumer also gives consent to their information being used for statistical and evaluation purposes to improve mental health services in Australia. They understand that this will include details about them such as date of birth, gender and types of services they use, but will not include their name, address or Medicare/Pension/Health Care Card numbers.

Consumer signature
Guardian/parent if child _____ ○ Or verbal consent
Tick if applicable Date _____

The referrer agrees that all information submitted in this referral is an accurate reflection of the consumer's support needs and is correct with no information withheld, so Medicare Mental Health can fulfill its duty of care to consumers, staff and other partner agencies.

Referrer signature _____ Date _____

Please attach Mental Health Treatment Plan (MHTP) or Child Treatment Plan (CTP) if available

Referral Notes (Any additional information that may support the consumer and referral)

The consumer and/or the referrer may be contacted for additional information.
All referred consumers will have an intake and assessment completed by Medicare Mental Health to determine service level and type (refer to: https://iar-dst.online/)

1800 595 212

Adelaide PHN Referrals
Fax 08 8121 1802 | email MedicareMHps.Adl@neaminational.org.au

Country SA PHN Referrals
Fax 08 9467 6233 | email MedicareMHps.CSA@neaminational.org.au

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Improving Mental Health and Wellbeing