Referral Form

Brisbane South Medicare Mental Health phone service

medicare

Mental Health
1800 595 212

Servicing people in the Brisbane South PHN catchment area. 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 that Medicare Mental Health is not a crisis service.

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

Referral Support Person

Contact if the consumer is unavailable. If the consumer is a child, provide the details of the responsible parent or guardian.

Relationship/role _____ Full name _____

Agency _____ Phone _____

Email _____

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 Brisbane South 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/)

Submit Referral Form

Phone 1800 595 212 | Fax 07 30894060 | MedicareMHps.BS@neaminational.org.auu

phn BRISBANE SOUTH
An Australian Government Initiative

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Improving Mental Health and Wellbeing