

Patient Information:			
First name			Last name
Address			Suburb Postcode
Gender	<input type="checkbox"/> M <input type="checkbox"/> F	DOB ___/___/___	Phone number
Medicare number			Country of birth
Main language spoken at home	<input type="checkbox"/> English <input type="checkbox"/> Arabic <input type="checkbox"/> Cantonese <input type="checkbox"/> Mandarin <input type="checkbox"/> Hindi <input type="checkbox"/> Spanish <input type="checkbox"/> Italian <input type="checkbox"/> Other (please specify)		
Spoken English level	<input type="checkbox"/> Very Well <input type="checkbox"/> Well <input type="checkbox"/> Not Well <input type="checkbox"/> Not at all		<input type="checkbox"/> Interpreter Required
Aboriginal and/or Torres Strait Islander	<input type="checkbox"/> No <input type="checkbox"/> Yes, Aboriginal <input type="checkbox"/> Yes, Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Unknown		
Marital status	<input type="checkbox"/> Never married <input type="checkbox"/> Married/De facto <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Unknown		
Homelessness	<input type="checkbox"/> Stable housing <input type="checkbox"/> Short-term/emergency accommodation <input type="checkbox"/> Sleeping rough		
Labour force status	<input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Not in the labour force <input type="checkbox"/> Unknown		
Employment type	<input type="checkbox"/> Full time <input type="checkbox"/> Part time/Casual <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown		
Source of income	<input type="checkbox"/> Paid employment <input type="checkbox"/> Nil income <input type="checkbox"/> Disability support pension <input type="checkbox"/> Other pension <input type="checkbox"/> Compensation payments <input type="checkbox"/> Other (super, investments etc.) <input type="checkbox"/> Unknown		
Health Care Card	Number: _____		<input type="checkbox"/> No
Financial hardship	<input type="checkbox"/> No <input type="checkbox"/> Yes		
NDIS registered	<input type="checkbox"/> No <input type="checkbox"/> Yes Number: _____		
Mental Health Presentations			
Presenting issues			
Principal diagnosis			
Anxiety disorders: <input type="checkbox"/> Panic disorder <input type="checkbox"/> Agoraphobia <input type="checkbox"/> Social phobia <input type="checkbox"/> Generalised anxiety	<input type="checkbox"/> OCD <input type="checkbox"/> Major depression <input type="checkbox"/> Depressive symptoms <input type="checkbox"/> Bipolar disorder	<input type="checkbox"/> Adjustment disorder <input type="checkbox"/> Oppositional defiant <input type="checkbox"/> Personality disorder <input type="checkbox"/> Conduct disorder <input type="checkbox"/> Complex PTSD	<input type="checkbox"/> Alcohol dependence <input type="checkbox"/> Drug dependence <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other: _____
Severity <input type="checkbox"/> Mild <input type="checkbox"/> Moderate Severe: <input type="checkbox"/> Acute or <input type="checkbox"/> Complex			
Psychotropic medication (please tick all that apply)			
<input type="checkbox"/> None <input type="checkbox"/> Hypnotics and sedatives <input type="checkbox"/> Psychostimulants and nootropics		<input type="checkbox"/> Antidepressants <input type="checkbox"/> Antipsychotics <input type="checkbox"/> Anxiolytics	
Outcome tool score	<input type="checkbox"/> K10 <input type="checkbox"/> K5 <input type="checkbox"/> SDQ <input type="checkbox"/> Other: _____ (Please attach form)		
Previous mental or physical health history or treatment			

Priority Group			
Is this person currently at high risk of suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Child (0-12 years) <input type="checkbox"/> Young adult (13-25 years) <input type="checkbox"/> CALD <input type="checkbox"/> Aboriginal and/or Torres Strait Islander <input type="checkbox"/> Refugee/Asylum Seeker <input type="checkbox"/> Severe and complex mental illness <input type="checkbox"/> Peri-natal <input type="checkbox"/> LGBTIQ <input type="checkbox"/> Elderly			
Treatments			
Referred for which strategies	<input type="checkbox"/> Psychological therapy		<input type="checkbox"/> Psychiatric services
	<input type="checkbox"/> Suicide prevention service		<input type="checkbox"/> Other: _____
Preferred WentWest Provider or Service	<input type="checkbox"/> No preference (Provider/service will be assigned by WentWest)		
	<input type="checkbox"/> Bulent Bill Ada, Life Psychologists, Suite 30, 20 Macquarie St. PARRAMATTA NSW 2150		
Additional Information e.g. anger, self-harm, grief			
Referrer Details			
Name		Profession	
Organisation type		Phone number	
Address		Fax number	
		HealthLink EDI	
Consent: Patient or parent/guardian for a child must be completed for the referral to be accepted			
<input type="checkbox"/> Referrer confirms that the patient understands and consents to the following:			
<ol style="list-style-type: none"> Understands that the information provided in this referral is required to determine eligibility for services with WentWest. Gives consent for services to be provided by suitable programs, as requested on this referral. Gives permission for the exchange of this information between Health Professional and other agencies for the purpose of coordination of care. Consents to de-identified information to be used for statistical purposes for WentWest and the Department of Health. 			
Referrer name: _____ (include name for forms sent via HealthLink)		Referrer signature: _____	
		Date: _____	
Please ensure the following is complete before sending to WentWest:			
<ul style="list-style-type: none"> ✓ Patient contact information including phone number ✓ Financial and priority group information including Health Care Card number ✓ Mental Health Treatment Plan, outcome tool or medication list (psychiatric service is attached) ✓ Consent section above. 			
Send completed form and Mental Health Treatment Plan via: Secure Fax: (02) 8208 9941 or HealthLink EDI: wntwstmh			