

Please contact 1800 223 365 to obtain referral code

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

Blue Mountains | Hawkesbury | Lithgow | Penrith

DAVID BEST 11/3/1968

Referral Date	Patients initials	Year of Birth	M / F / Other	Postcode
17/09/24	D.B	1968	M	2756

**MHNIP Referral Details:**

Referral Code	Nurse Name	Phone	Fax / Email
NBM 13143	Michelle Hookham		

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

Criteria 1*	Criteria 2*	Criteria 3*	Criteria 4*
<input checked="" type="checkbox"/> The patient has been diagnosed with an eligible mental health disorder: <b>List diagnosis:</b> Trauma Disorder	<input checked="" type="checkbox"/> The disorder causes significant disablement to the patients social personal and occupational functioning	<input checked="" type="checkbox"/> the patient is expected to require continuing treatment and management of their mental health disorder over the next two years	<input checked="" type="checkbox"/> 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? No

Does the patient live alone? Yes

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

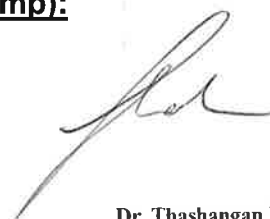
Is the patient receiving medication? Benzodiazepines, Anti-Depressants, Antipsychotics, Mood Stabilisers

Is there a history of aggression (physical or verbal) towards health professionals? (For safety assessment purposes. Will not affect acceptance of referral) No

**Reason For Referral** on-going counselling and therapy**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):**


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