Nepean Blue Mountain Primary Health Network Fax:0296736856

Patient Information					
First Name	Kim		Last Name	Graham	
Address	47 Grose Vale Rd		Suburb	NORTH RICHMOND	Postcode 2754
Gender	Female	D.O.B. 3/10/1971	Phone Number	0420 828 850	
Medicare Number	2351 63471 9 / 1		Country of Birth	Australia	
Main Language Spoken at Home	[x] English [ ] Arabic [ ] Cantonese [ ] Mandarin [ ] Hindi [ ] Spanish [ ] Italian [ ] Other (please specify)				
English Level (spoken)	[ ] Very Well [x] Well [ ] Not Well [ ] Not at all		[ ] Interpreter Required		
ATSI	[x] No [ ] Yes, Aboriginal [ ] Yes, Torres Straight Islander [ ] Yes, both [ ] Unknown				
Marital Status	[ ] Never married [ ] Married/De facto [ ] Widowed [ ] Divorced [x] Separated [ ] Unknown				
Homelessness	[x] Stable housing [ ] Short-term/emergency accommodation [ ] Sleeping rough				
Labour Force Status	[ ] Employed [x] Unemployed [ ] Not in the labour force [ ] Unknown **(For child/youth referrals please complete with parents status)**				
Employment Type	[ ] Full time [ ] Part time [ ] Not applicable [ ] Unknown **(For child/youth referrals please complete with parents status)**				
Source of Income	[ ] Paid Employment [ ] Nil income [ ] Disability support pension [x] Other pension [ ] Compensation payments [ ] Other (super, investments etc.) [ ] Unknown **(For child/youth referrals please complete with parents status)**				
Health Care Card	Number: [ ] No card				
NDIS Registered?	[x] No [ ] Yes Number:				

Mental Health Presentation

Presenting Issues: [ ] See attached Mental Health Treatment Plan

jus been told she brain aneurysm still under investigation , acute break down ably supported by son n her present psychologist, gradualover coming grief, insomnia teary withdrawn n do not wish to go out n socialise , introverted

Principal Diagnosis

Anxiety Disorders:	[ ] OCD	[x] Adjustment disorder	[ ] Alcohol dependence
[ ] Panic disorder	Depressive Disorders:	[ ] Oppositional defiant	[ ] Other drug dependence
[ ] Agoraphobia	[x] Major depression	[ ] Personality disorder	
[ ] Social phobia	[ ] Depressive symptoms	[ ] Conduct disorder	[ ] Schizophrenia
[x] Generalised anxiety	[ ] Bipolar Disorder	[x] Other: grief++++	

Severity [ ] Mild [ ] Moderate Severe: [x] Acute or [ ] Complex

Psychotropic Medication *(please tick all that apply)*

[ ] None [ ] Antidepressants
[ ] Hypnotics & sedatives [ ] Antipsychotics
[ ] Psychostimulants & nootropics [ ] Anxiolytics

Outcome Tool Score: [x] K10 [ ] KS [ ] DSQ [x] Other: DSMIV *(Please attach form)*

Previous Mental Health History or Treatment: [x] See attached Mental Health Treatment Plan

yes in 2024

Physical Health Conditions to Note:

chronic necck pain from cervical spondylosis, Brain aneurysm

Priority Group

Suicide Prevention Referral:

Is this person currently at high risk of suicide? ☐ **Yes** ☒ **No**

☐ Child (0-12 years) ☐ Young Person (13-25 years) ☐ Aboriginal and/or Torres Strait Islander

☐ Severe & Complex Mental Illness

Vulnerable Group: ☐ CALD ☐ Peri-natal ☐ LGBTIQ ☐ Elderly ☐ Refugee/Asylum Seeker

Treatments

Referred for which strategies	☒ Psychological therapy	☐ Clinical care coordination
	☒ Low intensity psychological interventions	☐ Complex care package
	☐ Child and youth specific services	☐ Other: _____
	☐ Indigenous specific services	
Preferred Provider Or Service *(Refer to Website)*	Michelle Hookham @ 6 Christie St Windsor	☒ No preference (Provider/service will be assigned by WW clinician)

Additional Information

Referrer Details			
Name	Dr. Teng-Kiong Kek	Profession	Dr
Organisation type	MDMC	Phone Number	02 9625 8888
Address	253 Beames Ave	Fax Number	9832 7152
	MT DRUITT, NSW	Postcode	2770
REFERRER SIGNATURE		**DATE**	19/11/2024

CONSENT – Patient or Parent/guardian for a Child – MUST BE COMPLETED FOR THE REFERRAL TO BE ACCEPTED

(Cross out any statement that does not apply)

- *I have been informed of the role and services that WentWest provides.*
- *I understand that the information provided in this referral is required to determine my eligibility for services.*
- *I give my consent for services to be provided by suitable programs, as requested on this referral.*
- *I give permission for the exchange of this information between my GP and other agencies for the purpose of coordination of care.*
- *I consent to my de-identified information to be used for statistical purposes for WentWest and Department of Health.*

Signature: _____

Date: 19/04/2024

Please ensure the following is complete before sending to WentWest:

☐ **Patient contact information including phone number**

☐ **Financial and priority group information including HCC number**

☐ **Referrer and patient signatures**

☐ **MHTP & Outcome tool is attached**