

## Adult Mental Health Referral

Boab's Adult Mental Health Service assists clients with mild to moderate mental health issues.

Clinical responsibility lies with the referrer until a clinical service commences.

Should you require more urgent assistance, please consider the following services;

### Crisis Support Numbers

- RuralLink: After hours mental health service staffed by experienced community mental health professionals. Free call 1800 552 002
- Suicide Call Back Service: 1300 659 467
- Crisis Care WA: (08) 9233 1111, country free call 1800 199 008

- Lifeline: 13 11 14
- Samaritans: Free call 1800 198 313
- Men's Line: 1300 789 978
- Beyond Blue: 1300 224 636
- Kids Help Line: Free call 1800 551 800
- Alcohol and Drug Information Service: Free call 1800 198 024



**BROOME HOSPITAL**  
Robinson Street, Broome  
Phone: 9194 2222

**HALLS CREEK HOSPITAL**  
Roberta Ave, Halls Creek  
Phone: 9168 9222

**DERBY HOSPITAL**  
Clarendon Street, Derby  
Phone: 9193 3333

**KUNUNURRA HOSPITAL**  
Coolibah Drive, Kununurra  
Phone: 9166 4222

**FITZROY CROSSING HOSPITAL**  
Fallon Rd, Fitzroy Crossing  
Phone: 9166 1777

**WYNDHAM HOSPITAL**  
Minderoo Street, Wyndham  
Phone: 9161 0222

**Referral Date:**

**Referrer Name:**

**Referring Organisation:**

**Phone:**

**Fax:**

**Email:**

**Postal address to receive client correspondence:**

**Client name:**

**Date of Birth:**

Is this an approximate? ☐

**Gender:** ☐ Male ☐ Female ☐ Other ☐ Unspecified

**ATSI status:** ☐ Aboriginal ☐ Torres Strait Islander ☐ Neither

**Country of Birth:**

**Primary language:**

**English proficiency:** ☐ Not at all, ☐ Not well, ☐ Well, ☐ Very Well

**Medicare No:**

**Index:**

**Expiry Date:**

**Does the client have a current GP Mental Health Care plan:** ☐ Yes ☐ No ☐ No, but can be requested.

**Residential Address:**

**Postal Address:**

**Phone:**

**Mobile:**

**Work Phone:**

**Is the client currently employed:** ☐ Yes, Full-time ☐ Yes, Part-time ☐ No

**Carer Details &/or emergency contacts:**

**Other agencies involved in client care:**

**What is the principle diagnosis for the reason of referral:**

**Is there a secondary diagnosis:**

**What is the principle focus you are seeking this referral:**

☐ Psychological Therapy

(Primarily based around the delivery of Psychological therapy by a mental health professional. This category most closely resembles the previous service delivered under ATAPS)

☐ Low Intensity Psychological Intervention

(Primarily based around the delivery of time limited, structured psychological interventions for those with, or at risk of mild mental illness)

☐ Indigenous Specific MH Service

(Primarily based around the delivery of mental health services that are specifically designed to provide culturally appropriate services for ATSI people)

**Please indicate the medication (if any) the client is currently taking:**

☐ Antipsychotics, ☐ Anxiolytics, ☐ Hypnotics/Sedatives, ☐ Antidepressants, ☐ Psychostimulants/Nootropics

**Mental State Examination:**

**What are the presenting issues?**

**What are the client's motivations and goals?**

**Please provide some history on the client, their family history, social supports and cultural factors:**

**Please note any risks of self-harm, harm to others, any substances use, housing or legal issues:**

**BEFORE SUBMITTING THE REFERRAL PLEASE ENSURE;**

- ☐ Client has consented to the referral and has agreed for us to contact them for an appointment.
- ☐ The referral form above has been completed in its entirety.
- ☐ The K10+ attached below has been completed and attached.
- ☐ GPMHCP and any other applicable documents have been attached.

**Once completed, please direct to Boab's Mental Health Team –**

MMex: [bhsmht@mmex.gsmhn.com.au](mailto:bhsmht@mmex.gsmhn.com.au)

Fax: (08) 9192 7999

Email: [reception@boabhealth.com.au](mailto:reception@boabhealth.com.au)

Surname:	
Other names:	
Date of Birth:	Sex:
____/____/____	Male <input type="checkbox"/> _ Female <input type="checkbox"/> _
Address:	

Date completed: \_\_\_ / \_\_\_ / \_\_\_\_

The following ten questions ask about how you have been feeling in the **last four weeks**. For each question, mark the circle under the option that best describes the amount of time you felt that way.

		None of the time	A little of the time	Some of the time	Most of the time	All of the time
1.	In the last four weeks, about how often did you feel tired out for no good reason?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.	In the last four weeks, about how often did you feel nervous?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3.	In the last four weeks, about how often did you feel so nervous that nothing could calm you down?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.	In the last four weeks, about how often did you feel hopeless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5.	In the last four weeks, about how often did you feel restless or fidgety?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.	In the last four weeks, about how often did you feel so restless you could not sit still?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7.	In the last four weeks, about how often did you feel depressed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8.	In the last four weeks, about how often did you feel that everything was an effort?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9.	In the last four weeks, about how often did you feel so sad that nothing could cheer you up?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10.	In the last four weeks, about how often did you feel worthless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please turn over – there are a few more questions on the other side

The next few questions are about how these feelings may have affected you in the **last four weeks**. You need not answer these questions if you answered 'None of the time' to all of the ten questions about your feelings

11.	In the last four weeks, how many days were you TOTALLY UNABLE to work, study or manage your day to day activities because of these feelings?	_____ (Number of days)
12.	[Aside from those days], in the last 4 weeks, HOW MANY DAYS were you able to work or study or manage your day to day activities, but had to CUT DOWN on what you did because of these feelings?	_____ (Number of days)
13.	In the last 4 weeks, how many times have you seen a doctor or any other health professional about these feelings?	_____ (Number of consultations)
14.	In the last 4 weeks, how often have physical health problems been the main cause of these feelings?	<div style="text-align: right;"> None of the time <input type="radio"/>  A little of the time <input type="radio"/>  Some of the time <input type="radio"/>  Most of the time <input type="radio"/>  All of the time <input type="radio"/> </div>

**Thankyou for completing this questionnaire.**

Please return it to the staff member who asked you to complete it.