Northern Queensland Medicare Mental Health phone service

Connection Form

Forward completed referral via Medical Objects ID: **MENTAL HEALTH NQLD REFERRALS, MEDICARE (TH4218000D3)** or via email to: mmh-nqld@pccs.org.au Phone: 1800 595 212

Servicing people in the Northern Queensland PHN area, 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.

Whether you know what service is required, or the person you are referring needs help to explore options, the Medicare Mental Health Phone Service team can help find services or supports to assist.

If the person has acute mental health needs, please refer to MH Call on 1300 64 22 55.

About the person you are referring				
Full Name				
Preferred Name				
Date of Birth				
Address				
Phone Number				
Email				
Preferred contact method (select all that apply)	Phone call	☐		
	Text	☐		
	Email	☐		
Is the person comfortable with us contacting a family member, friend, or other support person if we are unable to reach them?	Yes	☐	No	☐
	Name			
	Relationship			
If so, please complete the details.	Phone number			
Is an interpreter required?	Yes/No			
	If yes, please specify language.			
Is there anything else important to share about the person you are referring? E.g ethnic background, gender				

identity, preferred practitioner gender, etc	

Referral notes	
What does the person want help with?	
Do they know what type of service or support they want?	
Based on your patient's input, as the referring GP, do you have any recommendations about suitable services or supports?	
Are there any particular challenges or situations that will make it hard for the person to engage in a service or support? *E.g. transport*	

About the referring GP		
Full Name		
Address		
Practice name		
Contact details	Phone	
	Email	

About the care team – Who would the person you're referring like to keep updated about their care journey?
Please provide Name, Role/Organisation and contact details

If you have completed a Mental Health Treatment Plan (MHTP) or used the Initial Assessment and Referral Decision Support Tool (IAR-DST) please attach with the referral.

Consent to share information

By consenting to this referral, the person is consenting to the sharing of their personal information. The information contained in the referral is used by the Head to Health Phone Service to:
(1) deliver assessment and referral services,
(2) for monitoring, aggregate reporting and evaluation purposes to improve quality and access to care.
This information will be passed on to the recommended provider who will contact the person.

Please indicate this form's information has been discussed and provided to the patient. ☐ Y ☐ N
Patient or Parent/Guardian/Carer consents to referral? ☐ Y ☐ N
Referrer consents to the collection and storage of referrer details on internal database? ☐ Y ☐ N