Northern Queensland Medicare Mental Health phone service

Connection Form – Individual or Service Provider Referral

Forward completed referral 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 own wellbeing or wanting support for someone they care about, or a client of their service.

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 you or 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	☐		
Are you or the person you're referring comfortable with us contacting a family member, friend, or other support person if we are unable to make direct contact? If so, please complete the details.	Yes	☐	No	☐
	Name			
	Relationship			
	Phone number			
Is an interpreter required?	☐ Yes ☐ No			
	If yes, please specify language.			
Any other important things about you or the person being referred?	E.g ethnic background, gender identity, preferred practitioner gender, etc			

Referral notes	
What do you / the person being referred want help with?	
Do you/they know what type of service or support would be most helpful or suit them best?	
Service providers only – do you have recommendations for suitable services or supports?	
Are there any particular challenges or situations that will make it hard for you or the person to engage in a service or support? *E.g. transport, location*	

About the referring service provider		
Full Name		
Address		
Organisation name		
Contact details	Phone	
	Email	

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

Service Providers - If you have 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 Medicare Mental 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.

Individual / Self-Referral:
Please indicate that you understand this consent to share information ☐ Y ☐ N

Service Provider Referral:
Please indicate this information has been provided and understood by the person being referred ☐ Y ☐ N

You or the Parent/Guardian/Carer consents to referral? ☐ Y ☐ N

Referrer consents to the collection and storage of referrer details on internal database? ☐ Y ☐ N