

**Gold Coast Primary Health Network**

**Psychological Services Program**

**Provisional Referral (not for GP use)**

**Suicide Prevention**

Gold Coast Primary Health Network (GCPHN) can provide short term psychological intervention with an approved Psychological Services Mental Health Professional, for financially disadvantaged people who have self-harmed, attempted suicide, or have experienced suicidal ideation and are being discharged by the Acute Care Team.

**Please note:** The Psychological Services Suicide Prevention Program is not a crisis service and when considering if a person requires access to psychological services, all referral options should be considered.

**Person requires psychological services**

Referral options available:

|  |  |  |  |
| --- | --- | --- | --- |
| Person already has their own Psychologist – refer direct. | Information provided about online e-mental health services. | Better Access - a referral could occur anytime from beginning of care planning. This could be via GP Mental Health Treatment Plan completed prior to or during transition phase. | GCPHN Psychological Services Program - a referral could occur anytime from beginning of care planning. This could be via GP Mental Health Treatment Plan completed prior to or during transition phase. A provisional referral can also be made. The assessment and safety plan must be provided with the referral. |

**Eligibility Criteria**

Eligible individuals for the GCPHN Psychological Services Program should be experiencing financial hardship (document evidence in Additional Information) and have symptoms of which can benefit from short term psychological intervention.

**How to access the GCPHN Psychological Services Program - Suicide Prevention**

A provisional referral can be made for individuals who are engaged in the Gold Coast Mental Health Suicide Prevention Pathway at any time from the beginning of care planning if the individual is deemed eligible for the service. Provisional referrals can be made directly by a member of the Gold Coast University Hospital, Robina Hospital Acute Care Teams and Tweed Hospital Acute Care Team for Queensland residents.

This referral form is to be completed by clinicians after determining the client’s eligibility for the Program and must include, with the client’s authority, a summary of presenting concerns related to Suicide/Self Harm.

The patient Safety Plan must accompany this referral. This form and the safety plan is then forwarded to PCCS Intake via secure **Fax: 07 3186 4099.**

**Important - If the client is referred by a Provisional Suicide Prevention Referral, the client must visit their regular General Practitioner (GP) within 2 weeks of referral, to have a Psychological Services Program Referral and Mental Health Treatment Plan prepared.**

Referrals can also be made by the client’s GP, which can be suggested by the Acute Care Team.

For further enquiries about the Psychological Services Program, please contact PCCS Intake Team:

Phone: (07) 3186 4000. Email: GCTX@pccs.org.au or visit [www.healthygc.com.au](http://www.healthygc.com.au)

**Referral Process:**

1. Assess the client and determine eligibility.

2. Confirm client is experiencing financial disadvantage (document evidence in ‘*Additional Information’*.

3. Obtain client consent for Provisional Referral and sharing of information including the Safety Plan.

4. Complete Psychological Services Program Suicide Prevention Provisional Referral form (on next page) and email PCCS Intake at GCTX@pccs.org.au or secure fax: 07 3186 4099.

5. Advise client they are required to attend an appointment with their regular GP for a Psychological Services Program Referral and Mental Health Treatment Plan. This needs to occur within the next 2 weeks of referral date otherwise client is unable to access further sessions.

6. The Referrer completing this referral must also sign (*see next page*).

**Suicide Prevention**

|  |  |
| --- | --- |
| Name of Practitioner completing referral*: this must be completed* | Date:  |
| Discipline of referring Practitioner:  |
| Workplace of referring Practitioner: |
| Phone:  | Fax: | Email: |
| I the above named Practitioner believe this client meets the eligibility criteria for the Psychological Services Program Suicide Prevention, as set out on page one (1),  |
| **Signature of Practitioner completing the referral:** |
| **Does the client have a preference for gender of Mental Health Professional? 🗌 Y 🗌 N Male / Female (please circle)** |
| **Name of preferred Psychological Services Mental Health Provider** *(if known):* |

**Client Details:**

|  |  |
| --- | --- |
| Client Name:  | D.O.B: |
| Daytime Contact Number: | Mobile: | Gender: 🗌 M 🗌 F 🗌 X (Other) |
| Address: |
|  |
|  | Postcode: |
| Health Care/ Pension Card No: Expiry Date:  |
| As part of your assessment of the patient, do you consider them financially disadvantaged? |
| Next of Kin/Guardian: | Relationship to Patient:  |
| **Contact Details of Client’s GP** |
| GP Name: |
| Practice Name: | Phone Number: |
| Appointment made with their GP for a Psychological Services Program Referral and Mental Health Treatment Plan? 🗌 Y 🗌 N Date: |
| Address:  |
|  | Postcode: |
| Does the client speak a language other than English? **🗌 Y 🗌 N**  |
| If yes, how well does the client speak English? 🗌 Very Well 🗌 Well 🗌 Not Well 🗌 Not at all  |
| Does the client identify as Aboriginal or Torres Strait Islander? 🗌 No 🗌 Aboriginal 🗌 Torres Strait Islander 🗌 Both  |
| What is the highest level of education the client has completed? 🗌 Primary 🗌 Year 10 🗌 Year 11 🗌 Year 12 🗌 Tertiary |
| Does the client have access to transport? 🗌 Y 🗌 N | Is the client a low-income earner? 🗌 Y 🗌 N |
| Additional Information relating to this referral:  |

|  |
| --- |
| **Client Consent:**I consent to the sharing of information, relevant to my referral and treatment, between Queensland Health, Gold Coast Primary Health Network, my GP and the Psychological Services Program Mental Health Professional allocated my referral.Any information collected from clients will be stored according to each organisation’s strict privacy and confidentiality policies. |
| Client’s Signature: | Date:  |

Please forward this referral to the **PCCS Intake** Team:

Secure Fax: 07 3186 4099 Email: GCTX@pccs.org.au Phone: 07 3186 4000