

METRO HOME LINK MENTAL HEALTH REFERRAL FORM



Government of
South Australia

PAGE TWO (HAVE YOU COMPLETED PAGE 1?)

PATIENTS NAME:

DOB:

OHS Issues: Orders, Challenging behaviours, violence, suicidal, animals access, other:

CURRENT SERVICES INVOLVED or REFERRED TO

ACIS Yes No Details/Contacts

Referred Date: / /

Adult MH Comm. Team Inc. H@H Yes No Details/Contacts

Referred Date: / /

MHSOP Yes No Details/Contacts

Referred Date: / /

Dom Care/Options Yes No Details/Contacts

Referred Date: / /

Rehab pack eg. Strat 6 Yes No Details/Contacts

Referred Date: / /

Other Supports: e.g. CSI

Referred Date: / /

CARE REQUIRED

Short Term Accommodation Funding / support:

Transport Home or to appointments / Escort needed?:

Allied Health (Psychologist, Occupational Therapist, Physiotherapist):

Child Care/ After School Hours Support :

Carer Support:

Meal service / Food:

Shopping Assistance:

House Cleaning / Domestic assistance:

Nursing Care/Medication Supervision:

Personal Care assistance:

Medical Equipment:

Other:

ATTACH and FAX ANY OTHER INFO YOU FEEL WILL ASSIST MHL
A MEDICATION AUTHORITY IS MANDATORY IF THE PERSON REQUIRES MEDICATION SUPERVISION