FM117 ASSERTIVE COMMUNITY TREATMENT (ACT) REFERRAL FORM

Date Referral Made:		
Patient Name:		
Gender: Male ☐ Female ☐	Date of Birth:	
Patient Address:		
Phone No: (Home)	(Mobile)	(Work)
Private Health Insurance Fund: Medicare Number:	Membership Number: Expiry Date:	
Reason for Referral: (presenting complaint, current condition, psychiatric history, substance use, and management)		
Diagnosis:		
Medication:		
Allergies:	Involuntary treatment order: YES ☐ NO ☐	
Risk Factors/Alerts: (violence, self harm, suicide, other)		

MANDATORY REQUIREMENTS	RATING
1. Resides within the service catchment area for most of a 6 month period	YES / NO
2. Has a major psychiatric condition where the primary diagnosis is not intellectual impairment of drug dependence/abuse	YES / NO
3. Has had prolonged, frequent, or multiple inpatient admissions to hospital OR; based on assessment and clinical profile, exhibits the potential for multiple and/or prolonged inpatient admissions	YES / NO
4. Assessed a being NOT at high risk of self-harm and NOT requiring a safe environment with a higher level of clinical supervision and monitoring.	YES / NO
5. Is NOT a nursing home type patient.	YES / NO
6. Referred by a psychiatrist	YES / NO
7. Patient consents to ACT Program service involvement	YES / NO

SCORING CRITERIA	SCORE	MAXIMUM RATING
8. Requires constant clinical input that is more than twice weekly face to face contact.		**9**
9. Unstable accommodation		**8**
10. Inadequate support systems		**7**
11. Poor living skills		**6**
12. Unable to benefit from existing services because of;		
a. Inability to independently access them.		**1**
b. Lack of/poor insight		**1**
c. Lack of motivation		**1**
d. Inability to organise self		**1**
e. Physical limitations		**1**
TOTAL SCORE		**35**
Note: To be considered for ACT Program services the patient must meet all the mandatory requirements and score a total of 16/35 points or higher.		

Psychiatrist Name: ________________________ **Signature:** ____________________________

Office Use Only:	
Date referral received:	Database updated: YES ☐ NO ☐
Health Insurance Fund Check: YES ☐	Consent: YES ☐ NO ☐
Financial to start on ACT: YES ☐ NO ☐	Case Manager assigned: YES ☐ NO ☐
Any excess stipulations: YES ☐ NO ☐	Psychiatrist notified of outcome: YES ☐ NO ☐
Stipulation:	Health Information Manager notified: YES ☐

Office Use Section Completed By:

Name: ____________________________________ Signature: ______________________________

PATIENT CONSENT FORM

I (print name) ____

Or ____.(guardian/responsible person)

As a patient of Dr ____

I consent / do not consent (please circle) to participate in the Toowong Private Hospital – Assertive Community Treatment (ACT) Program.

I agree that whilst on the Program:

- I will observe the advice of my Psychiatrist
- I will observe the Hospital policies published in Patients Rights and Responsibilities to which I will be taken to have agreed unless I promptly notify the Director of Clinical Services otherwise
- I will pay the Hospital for its services
- I have indicated my consent to use information on the Consent to Use Information Form

In giving this consent I (or guardian/responsible person):

- Have read the attached, Patient and Carer Information Sheet and understand the services to be provided.
- Have been given the opportunity to ask questions about the service, the type of information that will be collected and how it will be used.
- Have been provided with information about my rights and responsibilities.
- Have been provided with the Consent to Use Information Form
- Understand that the care and service I receive through participation in the ACT Program will be planned and organised in collaboration by my treating psychiatrist and the Toowong Private Hospital clinician/s.
- Understand that I will be asked to complete questionnaires measuring mental health, well-being, functioning and satisfaction during the program.
- Understand that as a voluntary patient I can withdraw at any time from the ACT Program by informing my treating psychiatrist and/or the Toowong Private Hospital staff.

I nominate ______________________________ as my carer. I consent / not consent for my nominated carer to be involved in my participation in the ACT program.

Signature: ____________________________________ **Date:** _______________

____

Patient (or Guardian) Name