South West Mental Health Portal

To Be Eligible Client Must Meet Criteria Below (*please tick boxes as indicated*)
☐ *Currently not in crisis or in need of urgent assistance*
☐ *Must be financially disadvantaged (eg. HCC or unemployed) or not have access to alternative* ***PLEASE SELECT REASON:*** ☐ HCC ☐ Unemployed ☐ Financial Hardship
Please indicate program being referred to: ☐ **Emotional Wellbeing Program** (CBT psycho education, up to 3 sessions) ☐ **Psychological Therapy** (up to 6 sessions) ☐ **Clinical Care Coordination** (GP management support for severe mental illness) ***See Oseca website for further information www.oseca.com.au***

Client Details			
Pension / HCC #:		Address:	
NDIS Participant: ☐ Yes ☐ No			
Surname:		Postal Address (if different):	
First Name:			
D.O.B:	Email:		Phone:
Gender: ☐ Male ☐ Female ☐ Indeterminate/Intersex/Unspecified			
Emergency Contact Name:	Relationship to client?		Phone:
Parent/Guardian Name (if under 16):			Phone:

IMPORTANT: Please complete the following questions					
Do you identify as:	☐ Aboriginal	☐ Torres Strait Islander	☐ Both	☐ Neither	
Type of employment?	☐ Full-time	☐ Part-time	☐ Unemployed	☐ Not in Labour Force	
Homelessness?	☐ No	☐ Short-term emergency	☐ Sleeping rough		
Perinatal?	☐ No	☐ Yes			
Marital Status?	☐ Divorced	☐ Defacto	☐ Married	☐ Separated	☐ Single ☐ Widowed
Country of Birth?	☐ Australia	☐ Other *(please specify)*:			
Main language spoken at home?	☐ English only	☐ Other *(please specify)*:			
How well does this person speak English?	☐ Very Well	☐ Well	☐ Not Well	☐ Not at all	

Oseca Mental Health Service is funded by Department of Health through **WAPHA** (Western Australia Primary Health Alliance)

South West Mental Health Portal

Reason for Referral

Mental Health Diagnosis / History

Current Medications / Significant Health History / Diagnosis

Referrer Details: Please complete all sections	
Name:	Ph:
Practice/Organisation:	Fax:
Name of client GP if not the referrer:	Practice:

Consent	
I have discussed this referral with the client and the client consents to being referred to Oseca Mental Health Service. **Please note: the referred person may not be contacted for up to seven calendar days.**	
Referrer Signature:	**Date:**

Oseca Mental Health Service is funded by Department of Health through **WAPHA** (Western Australia Primary Health Alliance)

South West Mental Health Portal

K10 +	None of the time	A little of the time	Some of the time	Most of the time	All of the Time
1. In the last four weeks, about how often did you feel tired out for no good reason?	1	2	3	4	5
2. In the last four weeks, about how often did you feel nervous?	1	2	3	4	5
3. In the last four weeks, about how often did you feel so nervous that nothing could calm you down?	1	2	3	4	5
4. In the last four weeks, about how often did you feel hopeless?	1	2	3	4	5
5. In the last four weeks, about how often did you feel restless or fidgety?	1	2	3	4	5
6. In the last four weeks, about how often did you feel so restless you could not sit still?	1	2	3	4	5
7. In the last four weeks, about how often did you feel depressed?	1	2	3	4	5
8. In the last four weeks, about how often did you feel that everything was an effort?	1	2	3	4	5
9. In the last four weeks, about how often did you feel so sad that nothing could cheer you up?	1	2	3	4	5
10. In the last four weeks, about how often did you feel worthless?	1	2	3	4	5
TOTAL OUT OF 50					

The next few questions are about how these feelings have affected you in the last four weeks. You need not answer these questions if you answered **"NONE OF THE TIME"** to all of the ten questions about your feelings.					
11. In the last four weeks, how many days were you TOTALLY UNABLE to work, study or manage your day to day activities because of these feelings?					
12. [Aside from those days], in the last four weeks, HOW MANY DAYS were you ABLE to work, study or manage your day to day activities but had to CUT DOWN on what you did because of these feelings?					
13. In the last four weeks, how many times have you seen a doctor or any other health professional about these feelings?					
14. In the last four weeks, how often have physical health problems been the main cause of these feelings? Please circle.	**None of the time**	**A little of the time**	**Some of the time**	**Most of the time**	**All of the Time**

Oseca Mental Health Service is funded by Department of Health through **WAPHA** (Western Australia Primary Health Alliance)

South West Mental Health Portal

Please FAX this referral form to Oseca on Fax : 9754 2985 or via Healthlink (gpdsmhcc)

or email swprograms@oseca.com.au

PLEASE PROVIDE YOUR CLIENT A *COPY* OF THIS REFERRAL

INFORMATION FOR CLIENTS

Oseca will contact you to book your initial appointment.

If you have not had contact within 14 days, please contact Oseca on 1300 680 431

Oseca Mental Health Service is funded by Department of Health through **WAPHA** (Western Australia Primary Health Alliance)