



Referral to Helen Mayo House

Perinatal and Infant Mental Health Service

Helen Mayo House
Ph: 08 8303 1183
Fax: 8357 9717
226 Fullarton Rd.
Glenside SA 5065
www.wch.sa.gov.au/hmh

Who can refer to HMH?

Medical Practitioners, Acute Crisis Intervention Service and Mental Health Clinicians.

Eligibility criteria for referral:

- Women with severe mental health problems whose child or children are aged 0-3 years and there is a major impact on their level of functioning and/or ability to parent.
- Substance abuse and alcohol use is not tolerated on the ward and women with substance and alcohol dependencies will only be considered following completion of withdrawal and detox.

How to make a referral:

1. Assess mother for severe mental health issue & eligibility for referral to HMH
2. Complete attached form and return to HMH. **Fax: 08 8357 9717**
3. HMH will notify you within 3 days of the status of the referral
4. If appropriate, your referral will be prioritised and placed on the HMH waiting list.
5. The waiting list will be reviewed periodically. To ensure that your referral is appropriately prioritised HMH request regular updates regarding the mental health status of your client. Especially when the clinical status of the client changes. This can be done via Fax: 08 8357 9717. A progress report template is available from the HMH website: <http://www.wch.sa.gov.au/hmh>

HMH is not an emergency service. For urgent assistance and intervention please contact ACIS on 13 14 65.

Waiting for admission:

- When there are no available beds HMH will prioritise referrals with psychiatrically urgent admissions taking priority. *For example:* Women with severe mental health problems and who are breast feeding young infants have a higher priority for admission.
- Due to the priority admission process it is difficult to predict admission times and admission cannot be guaranteed. Historically waiting times for admission have been anywhere between several weeks to several months for lower priority referrals. When a bed becomes available a HMH staff member will contact you and your client.

Support services:

Women, children, fathers, partners and their families need ongoing support whilst waiting for admission. The following services have been identified as providing support and referral to community services, (please note that this list is not exhaustive):

- Post and Ante Natal Depression Association (PANDA) ph: 1300 726 306 www.panda.org.au
- Child and Youth Health Centres (CYH) ph: 1300 733 606 www.cyh.com
- Women's Health State-wide: ph: 1300 882 880 www.whs.gov.au
- ACIS 13 14 65
- Various Mental Health services such as access to Psychologists, Psychiatrists etc are available through a *Mental Health Care Plan* from GPs. These services are covered by Medicare.



Helen Mayo House

Perinatal and Infant Mental Health Service

Referral Form

* Indicates mandatory fields

Source of Referral

* Name of Referrer: _____ * Contact ph: _____
* Fax: _____

Agency and/or Team: _____ Postal Address: _____

Days available for contact (please circle): **Mon Tues Wed Thur Fri** * Date of referral: _____

Client's Details

* Surname: _____ * DOB: _____ * Sex: **M** or **F**
* Given Name: _____ Age: _____ ATSI: **Y** or **N**
Address: _____ Ph: * (h) _____ * Language Spoken:
_____ *(m) _____ Interpreter required: **Y** or **N**

* GP: Name: _____ * Ph: _____ Name of Practice: _____

* Next of Kin: _____ * Relationship to client: _____

* Contact details (phone): (h) _____ (m) _____ (w) _____

Children's Details

Please tick the # box to indicate intended child for admission with mother

*#	* Child Name	* DOB	* Hospital of Birth	* Sex	* Breastfeeding
	1.	/ /		M or F	Y or N
	2.	/ /		M or F	Y or N
	3.	/ /		M or F	Y or N
	4.	/ /		M or F	Y or N

For ADMITTING children only: If there are any particular issues or concerns for the child(ren)'s mental or physical health, please detail this below:

Risk Assessment for Mother

Circle the relevant box for each domain. (For explanation of categories, please see Appendix A)

* RISK OF HARM TO SELF	None	Low	Moderate	Significant	Extreme
*RISK OF HARM TO OTHERS (INCLUDING INFANT)	None	Low	Moderate	Significant	Extreme
* LEVEL OF PROBLEM WITH FUNCTIONING	None/Mild	Moderate	Significant Impairment in one area	Serious Impairment in several areas	Extreme Impairment
*LEVEL OF SUPPORT AVAILABLE	No problems /Highly Supportive	Moderately Supportive	Limited Support	Minimal	No support in all areas.
* ATTITUDE AND ENGAGEMENT TO TREATMENT	No Problem/ Very Constructive	Moderate Response	Poor Engagement	Minimal Response	No Response
* OVERALL ASSESSMENT OF RISK	LOW	MEDIUM	HIGH	EXTREME	

Mental Health History

* Diagnosis:	* Past Mental Health History: (incl. Family Hx, past admissions etc)	
*Has a Mental Health Care Plan been completed with this client? Y or N (if yes, please attach most recent copy)		
*Is the client currently taking Psychiatric Medication: Y or N (if yes, please specify below)		
* Medication:	* Dose:	* Prescribing Dr. & contact number
1.		
2.		
3.		
* Does the Client have any current physical health issues or co morbidities: Y or N (if yes, please provide a detailed description below including medication)		
* Does the client have any current Drug and Alcohol dependencies or known substance abuse: Y or N (if yes, please describe below)		
* Has a Parenting, Functional or Psychiatric Assessment ever been completed: Y or N Please attach assessment(s) report to referral		

Reason for Referral/Current Mental Health Status

** Detailed Description of Presenting Complaint AND Rationale for inpatient treatment:
(ie: signs and symptoms, onset, duration, stressors etc)*

Edinburgh Depression Scale Score (if completed):

Date and Name of assessor:

** Mental State at time of Referral(include specificities of risk of harm to self, infant, other):*

Current Supports

Please TICK () what supports or services are in place with this client:

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Partner |
| <input type="checkbox"/> Psychologist | <input type="checkbox"/> Mental Health Nurse/Clinician |
| <input type="checkbox"/> GP | <input type="checkbox"/> Adult Mental Health Service |
| <input type="checkbox"/> Family | <input type="checkbox"/> Other _____ |

Please outline your intended ongoing plan of care with this client until admission to HMH:

Has consent been granted from the client for this referral? **Y** or **N**

Legal and Child Protection Issues

Are there any current Forensic or Legal issues (incl. child protection orders): **Y** or **N**

(If yes, please provide details below and attach copy of any orders)

To the best of your knowledge have any child protection notifications been made: **Y** or **N**

Is the client aware of child protection issues or Families SA notifications?: **Y** or **N**

Families SA Case Manager (if applicable):

Name: _____ Phone: _____ Office Location: _____

To assist with prioritising your referral, please provide updates regarding your client's changing mental health status. Fax: 8357 9717 Attn: Intake Officer

HMH is not an immediate crisis care service and referrals will only be reviewed periodically. Therefore HMH cannot be responsible for responding to acute or crisis situations. If you require urgent acute or crisis intervention please contact ACIS Mental Health Tirage on 13 14 65 or your nearest hospital emergency department.

RISK ASSESSMENT GUIDE

RISK OF HARM TO SELF/OTHERS

0. None (no thoughts or action of harm).	1. Low (Fleeting thoughts of harming themselves or harming others but no plans/current low alcohol or drug use).	2. Moderate (current thoughts/distress/past actions without intent or plans/moderate alcohol or drug use).	3. Significant (current thoughts/past impulsive actions/recent impulsivity/some plans, but not well developed/increased alcohol or drug use).	4. Extreme (Current thoughts with expressed intentions/past history/plans/ unstable mental illness/ high alcohol or drug use, intoxicated/violent to self/others/ means at hand for harm to self/others).
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LEVEL OF PROBLEM WITH FUNCTIONING

0. None/Mild (No more than everyday problems/slight impairment when distressed).	1. Moderate (Moderate difficulty in social/occupational or school functioning/reduced ability to cope unassisted).	2. Significant Impairment in one area (either social, occupational or school functioning).	3. Serious Impairment in several areas (Social, occupational or school functioning).	4. Extreme Impairment (inability to function in almost all areas).
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LEVEL OF SUPPORT AVAILABLE

0. No problems/Highly Supportive (all aspects/most aspects highly supportive/self/family/professional/ effective involvement).	1. Moderately Supportive (Variety of support available, able to help in times of need).	2. Limited Support (few sources of help, support system has incomplete ability to participate in treatment).	3. Minimal (few sources of support and not motivated)	4. No support in all areas.
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ATTITUDE AND ENGAGEMENT TO TREATMENT

0. No Problem/ Very Constructive (Accepts illness and agrees with treatment/new client)	1. Moderate Response (Variable/ ambivalent response to treatment).	2. Poor Engagement (Rarely accepts diagnosis).	3. Minimal Response (Client never cooperates willingly).	4. No Response (Client has only been able to be treated in an involuntary capacity).
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