

# URGENT SUICIDE INTERVENTION PROGRAM REFERRAL FORM General Practitioners (GP)



**CANNING  
DIVISION**  
OF GENERAL PRACTICE LTD

**NB: ONLY to be used when referring patients who are currently suicidal or self harming  
AND who meet criteria for this program (please see referral criteria for further information)**

<b>DATE:</b>
<b>TIME:</b>

GP stamp/ or name and practice  
details:

<b>Patient Details:</b>	
<b>DOB:</b> /        /	<b>Male / Female</b>
<b>Address:</b>	
<b>Home telephone:</b>	<b>Mobile:</b>
<b>Patient Information:</b>	
Does the patient speak a language other than English at home? <input type="checkbox"/> No, English only spoken <input type="checkbox"/> Yes, please specify _____	
How well does the patient speak English? <input type="checkbox"/> Very well <input type="checkbox"/> Well <input type="checkbox"/> Not well <input type="checkbox"/> Not at all <input type="checkbox"/> Unknown	
Is the person Aboriginal or Torres Strait Islander origin? <input type="checkbox"/> No <input type="checkbox"/> Yes, Aboriginal <input type="checkbox"/> Yes, TSI <input type="checkbox"/> Unknown	
Does the patient: <input type="checkbox"/> Live alone <input type="checkbox"/> With partner <input type="checkbox"/> With family <input type="checkbox"/> With friend or carer	
What form of transport does the patient use? <input type="checkbox"/> Private vehicle <input type="checkbox"/> Bus <input type="checkbox"/> Train <input type="checkbox"/> Friend vehicle <input type="checkbox"/> Other	
Is the patient a low-income earner? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
What is the highest level of education the patient has completed? <input type="checkbox"/> Primary <input type="checkbox"/> Secondary Yr _ <input type="checkbox"/> Secondary Yr 11 <input type="checkbox"/> Secondary Yr 12 <input type="checkbox"/> Tertiary	
Is the patient receiving psychotropic medication? Y / N If yes, please specify below: <input type="checkbox"/> Mood stabilizers <input type="checkbox"/> Antidepressants <input type="checkbox"/> Anti psychotics <input type="checkbox"/> Minor tranquillisers _____	
Is the patient receiving other medication? Y / N If yes, please specify: _____	
Does the patient meet the criteria for a mental illness? Y / N If yes, please specify: _____	
Has the patient received past mental health care? Y / N If yes, please specify: _____	

**Please complete both sides of the referral form.  
Confidential Fax (08) 9458 0555 Mobile 0437 780 098**

**Reason for referral:**

<b>Risk Factors:</b>	<b>Low</b>	<b>Moderate</b>	<b>Significant</b>	<b>Extreme</b>
<b>Suicidal Thoughts</b>	<input type="checkbox"/> Occasional, fleeting thoughts	<input type="checkbox"/> Few thoughts each week	<input type="checkbox"/> Daily thoughts	<input type="checkbox"/> Persistent & uncontrollable
<b>Intent to Die</b>	<input type="checkbox"/> Minimal	<input type="checkbox"/> Unsure if wants to die or live	<input type="checkbox"/> Sees death as an escape	<input type="checkbox"/> Wants to die
<b>Problem Solving/ Hopelessness</b>	<input type="checkbox"/> Feels stuck, hopes things will change	<input type="checkbox"/> Some solutions, mild hopelessness	<input type="checkbox"/> Few alternative solutions, moderate hopelessness	<input type="checkbox"/> Sees suicide as only option, severe hopelessness
<b>Plan / Means</b>	<input type="checkbox"/> Vague ideas of ways and means	<input type="checkbox"/> Has plan, but not specific	<input type="checkbox"/> Clear plan and access to means	<input type="checkbox"/> Plan in progress, has means
<b>Self Harm</b>	<input type="checkbox"/> Mild, occasional self harm	<input type="checkbox"/> Moderate, regular self harm	<input type="checkbox"/> High, increasing in frequency	<input type="checkbox"/> High-Severe self mutilation
<b>Previous Attempts</b>	<input type="checkbox"/> 12 months or more ago	<input type="checkbox"/> Last 3-12 months	<input type="checkbox"/> Last 1-3 months	<input type="checkbox"/> Attempt within last month
<b>Opposing Beliefs</b>	<input type="checkbox"/> Several concerns or reservations	<input type="checkbox"/> Some concerns	<input type="checkbox"/> Very few concerns	<input type="checkbox"/> Non concerns
<b>Social Supports</b>	<input type="checkbox"/> Supports available	<input type="checkbox"/> Withdrawing from supports	<input type="checkbox"/> Regular support unavailable	<input type="checkbox"/> No supports identified
	↓	↓	↓	↓
<b>Level of Urgency</b>	<b>Timely:</b> response in 48-72 hrs	<b>Rapid:</b> response in 24 hrs	<b>Immediate response</b>	<b>Immediate response</b>

<b>Who is the person's main source of support?</b>	Name:
Phone number:	Relationship:

Is the patient aware of this referral?	Yes / No
Has the patient been given the Patient Information Sheet and After Hours Crisis Contacts List?	Yes / No

<b>Urgency of response to this referral is:</b>	<b>Please tick</b>
Extreme risk	<i>Not suitable: use ED or MH Services</i>
Significant risk	<i>Not suitable: use ED or MH Services</i>
Moderate risk (contact within 24 hours)	
Low risk (contact within 48-72 hours)	

<b>GP Signature:</b>	<b>Date:</b> /            /
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<b>Patient Signature:</b>	<b>Date:</b> /            /
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# CDGP Suicide Intervention Program Patient Information Sheet

## What is the CDGP Suicide Intervention Program? Privacy and Confidentiality

This program provides short term treatment and care to people at risk of suicide or self-harm in the Canning Division area.

A referral to this Program by your GP means that you can see an experienced Psychologist for an unlimited number of sessions, over a two month period. Your progress will be monitored by your Psychologists and GP. The program is free of charge.

If you have been referred to the program by a Hospital's Accident & Emergency Department, you will need to see your GP within one week to finalise the referral. If you do not have a GP, we can help you find one.

*Please note:* This service is not available for those who need immediate emergency response to suicide risk. **For 24 hour immediate crisis response please call MHERL on 1300 555 788.**

### Where Can You Access the Service?

Counselling services are provided at four locations. Your daytime contact phone number will be provided to a Psychologist who will contact you to arrange your first appointment.

Please note there are no childcare facilities available. It is also not recommended that anyone else (including children) be brought into the sessions unless by prior arrangement.

The Psychologist will receive a detailed Mental Health Referral from your GP. All the information about you will be kept confidential and in a secure place.

After the final session, the Psychologist will write a summary report of your progress to your GP. If there is any information that you do not wish the Psychologist to communicate to your GP please request that it be kept confidential.

The patient consent form which you will be requested to sign, contains a summary of Privacy Protocols. A full length version is available from your GP or Psychologist.

### Can You Access Your Information?

Yes, you have a right to request access to the information that the Counsellor keeps about you as part of the treatment process.

### Missed appointments

This is a valuable service that many people wish to access. It is important that you attend your scheduled appointments or cancel with as much notice as possible.

### Any Other Questions?

If you have any other questions about the CDGP Suicide Prevention Program, please contact the Canning Division of General Practice between Monday-Friday 8:30am-4:30pm on (08) 9458 0505.



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## **After Hours Crisis Contact List:**

### **Telephone:**

#### **Mental Health Emergency Line (MHERL)**

Available 24 hours, 7 days

Phone: Metro callers 1300 555 788 (local call)

#### **Community Emergency Response Team (CERT)**

Available 4:00pm to 8:30am, 7 days

Phone: 08 9334 3666

#### **ATAPS After Hours Suicide Support Service**

Available 5:00pm to 9:00am Weekdays

Available 24 hours on Weekends and public holidays

Phone: 1800 859 585 (local call)

### **Emergency:**

#### **Royal Perth Hospital**

Wellington Street Campus, Perth

Phone: 08 9224 2244

#### **Armadale-Kelmscott District Memorial Hospital**

Albany Highway, Mount Nassura

Phone: 08 9391 2175 emergency department

#### **Bentley Mental Health Service**

Mill Street Centre, Triage

Available 24 Hours, 7 days

Phone: 08 9334 3666



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## **CDGP Suicide Intervention Program Patient Consent Form**

I \_\_\_\_\_ (name) agree to participate in the Canning Division of General Practice (CDGP) Suicide Intervention Program. My GP is referring me to work with an experienced Psychologist over a maximum of two months in this program. I have read and understood the Patient Information Sheet.

### **The information collected about me will be used for:**

#### **1) Clinical Management**

The referring GP will initially send patient details via a confidential fax line to CDGP. A de-identification number will be recorded against each patient and the original referral form will be forwarded to my Psychologist. This information will be used for planning and managing my treatment. At the beginning and the end of my treatment the Psychologist will write a progress report and forward it to my GP. My GP and Psychologist may discuss my treatment. My treatment may also be discussed with my nominated allied health worker or support person.

#### **2) Program Evaluation**

The CDGP Suicide Intervention Program needs to be evaluated in order to meet Government requirements; therefore at my last appointment I will be asked to complete a short survey about the service. The information collected for evaluating the Program will not contain my name or address.

### **Information Management**

All clinical information collected about me is confidential. All information will be stored in a securely locked place. At any time I may request to see the information held about me. I understand that I can withdraw from the Program at any time I choose. I am aware that I may request that any detail of my personal information be kept confidential from my GP or Psychologist.

### **Privacy**

A privacy protocol for the CDGP Suicide Intervention Program has been developed which is available from your GP or Psychologist. Any Canning Division staff with access to patient records have signed confidentiality agreements.

Signature (Patient): \_\_\_\_\_

Signature (GP or Psychologist): \_\_\_\_\_

Date: \_\_\_\_\_