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| Shape  Description automatically generated with medium confidence | *Mental Health Act 2016***Referral to Complex Care Panel** |
| **Referrals to the Panel may be made by Directors (or equivalent) from:*** Queensland Health
* Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships
* Office of the Public Guardian
* Department of Children, Youth Justice and Multicultural Affairs
 |
| **Client’s details** |
| Please use block letters, if handwritten |
| **Surname:**Click or tap here to enter text. | **Given name(s):**Click or tap here to enter text. |
| **Residential address:**Click or tap here to enter text. |
| **Town / Suburb:**Click or tap here to enter text. | **State:**QLD | **Postcode:**Click or tap here to enter text. |
| **Date of birth:**Click or tap to enter a date. | **Guardian appointed?**[ ]  Yes   [ ]  No | **Contact details:**Click or tap here to enter text. |
| **Eligibility criteria** |
| Tick applicable boxes |
| The person has formal service system involvement for any two of the following: |
| [ ]  Mental illness[ ]  Intellectual disability[ ]  Child safety concerns | *Diagnoses for mental illness, if known (including substance use disorders):*Click or tap here to enter text. |
| or[ ]  The person has any one of the above, without formal system involvement |
| **In addition, the following criteria must be met:**[ ]  The person has been charged with a serious criminal offence which could (or has been) referred to the Mental Health Court[ ]  The person is likely to present serious risk to themselves or the community without intervention[ ]  The person is likely to benefit from high level cross agency oversight[ ]  Local/ Hospital and Health Service level stakeholder meetings and engagement (if able to occur) have not adequately addressed the complexities of the matter. |

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| **Additional information** |
| Please include details of:* Significant clinical issues
* Significant risk issues
* Any current support services
* Reference to Mental Health Court details (if known)
* Charge details (if known)
 | Click or tap here to enter text. |

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| **Referring Department** |
| Include name of the Department making the referral |
| **Applicant details** | **Name, position, and Department:**Click or tap here to enter text. |
| **Signature:** | **Date:**Click or tap to enter a date. |
| **Endorsement by panel member**Referrals must be endorsed by a Panel member prior to submitting this form | **Name, position, and Department:**Click or tap here to enter text. |
| **Signature:** | **Date:**Click or tap to enter a date. |
| **TO: Secretariat, Complex Care Panel (via** **MHA2016@health.qld.gov.au****)**  |