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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**](mailto:MHA2016@health.qld.gov.au)**)** | | |