

Profile: Psychosocial

If question is irrelevant or information not known, write Not Applicable or NA

Record Agency Assigned Consumer Identifier (initial contact agency)

or affix label here

Mental Health and Wellbeing

In the past 4 weeks about how often did you feel:

K10 scale	All of the time 5	Most of the time 4	Some of the time 3	A little of the time 2	None of the time 1
1 tired out for no good reason?					
2 nervous?					
3 so nervous that nothing could calm you down?					
4 hopeless?					
5 restless or fidgety?					
6 so restless you could not sit still?					
7 depressed?					
8 that everything was an effort?					
9 so sad that nothing could cheer you up?					
10 worthless?					

Total K-10 Score: _____

Recommended action: refer for primary care mental health assessment if total score is 16–29 and for a specialist mental health assessment if score is 30 or more.

Personal and Social Support

During the past 4 weeks, was someone available to help you if you needed and wanted help? For example if you:

- Felt very nervous, lonely or blue.
- Got sick and had to stay in bed.
- Needed someone to talk to.
- Needed help with daily chores.
- Needed help just taking care of yourself.

Yes, as much as I wanted

Yes, quite a bit

Yes, some

Yes, a little

No, not at all

*Consider referral and
activities of daily living*

Comment on personal and social support, including opportunities:

Family and Personal Relationships

Comments:

Disability

Is the person likely to be eligible for disability services?
(circle yes only if they clearly meet all of the criteria below)

Yes No D/K

Eligibility Criteria (tick)

- Has a disability attributed to an intellectual disability or a sensory, physical or neurological impairment or brain injury
- The disability is permanent or likely to be permanent
- Substantially reduced capacity in self-care/management or mobility or communication or learning
- Need for continuing support

Department of Human Services

1620402E



Office Use Only: Summarise issues and arising action using the Summary and Referral Information form

PP Page 1 of 1

Name: _____

Designation/Agency: _____

Sign: _____

Date: _____

Contact number: _____

If information becomes superseded, indicate below and record updated information on a new form

The information on this form has been superseded

Date: _____

Name: _____

Sign: _____