

K10 +	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. About how often do you feel tired out for no good reason?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
2. About how often do you feel nervous?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
3. About how often do you feel so nervous that nothing could calm you down?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
4. About how often do you feel hopeless?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
5. About how often do you feel restless or fidgety?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
6. About how often do you feel so restless you could not sit still?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
7. About how often do you feel depressed?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
8. About how often do you feel that everything was an effort?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
9. About how often do you feel so sad that nothing could cheer you up?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
10. About how often do you feel worthless?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
TOTAL OUT OF 50					

The next few questions are about how these feelings have affected you in the last four weeks. You need not answer these questions if you answered **"NONE OF THE TIME"** to all of the ten questions about your feelings.

11. How often do physical health problems be the main cause of these feelings?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
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Consent

- I have discussed this referral with the client and the client consents to being referred to Amity Health Connections Count.

Referrer Signature: _____ Date: _____

PLEASE PROVIDE YOUR CLIENT A COPY OF THIS REFERRAL

Please return this completed form and any other relevant documentation to Amity Health via one of the following methods:

Fax: 08 9842 2798

Email: query@amityhealth.com.au

For enquiries, contact Amity Health on 08 9842 2797 and speak with the Mental Health Coordinator or Senior Mental Health Clinician.

Information for Client

Amity Health will contact your residential care facility to arrange an appointment. If you have not heard from us within 7 days, ask your referrer to call 08 9842 2797.