GP INITIAL REFERRAL AND MHTP

Psychological Support Services (PSS)

THIS IS NOT A CRISIS SERVICE, if crisis assistance is required, please call the Mental Health Access Line on: **1800 011 511 or 000**

SUBMIT COMPLETED REFERRALS via SECURE FAX: 1300 112 489 or HEALTHLINK ID: CESPHNMH

DATE OF REFERRAL	/ /

PSS is for individuals who live, work or study in the Central and Eastern Sydney region with diagnosable mild to moderate mental health concerns, who may benefit from short term treatment, are unable to Access other available services including Better Access (Medicare subsidised psychological services) due to financial hardship (**Individual income < $55,000; family income < $130,000**) AND who fit into one of the below underserviced and/or hard to reach populations:

Program Eligibility ***(ALL eligibility criteria have been met)***

☐ Patient lives, works or goes to school in the Central and Eastern Sydney region

☐ Patient is experiencing mild to moderate mental illness, or severe mental illness and would benefit from short term psychological intervention

☐ Patient is not better suited to a crisis or specialist domestic violence services and is not involved in court or insurance matters

Does your patient meet the income threshold criteria for PSS (Individual Income <$55,000 or family income <$130,000)? Yes ☐ No ☐

Reason for Referral ***(Please only PICK ONE).***

❑ Young people (12-25 years). ☐ **Would you like this young person to be referred to a headspace centre near them?**

❑ Adult (low income)

❑ Individuals who identify as Lesbian, Gay, Bisexual, Transgender, Intersex and Queer/Questioning (LGBTIQ)

❑ Individuals experiencing perinatal depression and their partners. **What is the baby's date of birth (or due date)? ___/____/_____**

❑ Individuals who identify as from an Aboriginal and Torres Strait Islander background (K5)

❑ Individuals who identify as from a Culturally and Linguistically Diverse (CALD) background

❑ Individuals who have attempted, or who are at risk of suicide, or self-harm (non-acute)

❑ People with severe mental health concerns who may benefit from short term focused psychological intervention as part of their overall care.

❑ People with mild Intellectual disability who may benefit from short term psychological intervention when co-occurring mental health concerns are diagnosed.

❑ Resident of an aged care facility with or at risk of mild to moderate mental health

Name of facility? _____

Does the client have dementia? Yes ☐ No☐

Does the client have delirium? Yes ☐ No☐

If the client has had an MMSE what was the score? _____

GP DETAILS					
GP Name			Practice Name		
Practice postcode		Practice phone		Practice fax	
GP or practice email (For all correspondence)					
*** please note that if an e-mail address is not provided you will not receive referral confirmation.					

PATIENT DETAILS			
First Name		Last Name	
Date of Birth			
Marital Status	☐ Never Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Married/De facto		
Current Gender Identity	☐ Female ☐ Male ☐ Non-binary ☐ Not Stated ☐Transgender Female/Male-Female ☐ Transgender Male/Female-Male		
Address			
Suburb		Postcode	
Phone 1		Phone 2	
Healthcare Card	☐ Yes ☐ No	NDIS Participation	☐ Yes ☐ No
Country of Birth		Cultural Identity	
Aboriginal or Torres Strait Islander	☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Unknown		
Main language spoken at home			
Proficiency in spoken English	☐ Very Well ☐ Well ☐ Not Well ☐ Not at All		

MENTAL HEALTH SELF-ASSESSMENT TOOL (to be completed by patients over 16 years old)		
Assessment Tool Used: (e.g. DASS, K10) **The K5 must be used when referring patients who identify as Aboriginal or Torres Strait Islander**		
Total Score:		
Additional Questions	In addition to the assessment tool used, please ask patient to complete the following functionality questions.	
In the last 4 weeks:		
1	how many days were you totally unable to work, study or manage your day to day activities because of these feelings?	(Number of Days)

2	aside from those days, in the past four weeks, how many days were you able to work or study or manage your day to day activities, but had to cut down on what you did because of these feelings?	(Number of Days)
3	how many times have you seen a doctor or any other health professional about these feelings?	(Number of Consultations)

		None of the time	A little of the time	Some of the time	Most of the time	All of the time	Not stated / Missing
4	how often have physical health problems been the main cause of these feelings?	☐	☐	☐	☐	☐	☐

CO-MORBID ISSUES

Please indicate if the client has any of the below co-morbid issues

☐ Chronic physical illness
☐ Drug and alcohol issues
☐ Intellectual disability
☐ Psychiatric co-morbidity
☐ Personality issues
☐ Psychosocial stressors
☐ Suicidality

PATIENT CONSENT: *Referral cannot proceed without patient consent*

☐ Referring GP confirms that the patient understands and consents to the following;

- The attached Mental Health Treatment Plan/Review to be sent to CESPHN and agrees to the outlined goals and treatments
- That CESPHN collects and shares information within the requirements of the Privacy Act 1988, with the PSS Provider Organisation and treating Mental Health Professional
- For administration and evaluation purposes, the patient agrees to their clinical and non-clinical information being provided to CESPHN.
- That they will be contacted by the allocated PSS Provider Organisation or Mental Health Professional to arrange an appointment.
- That they may be contacted by CESPHN or its representative to complete a client experience of care survey

☐ Yes ☐ No

GP SIGNATURE:		**DATE:**	/ /

GP MENTAL HEALTH TREATMENT PLAN (MHTP) - PATIENT ASSESSMENT
(MBS ITEM NUMBER 2700/2701 OR 2715/2717)

PATIENT NAME		**DATE OF BIRTH**	/ /

CARER DETAILS AND/OR EMERGENCY CONTACT(S):

	NAME	**PHONE**
1.		
2.		
3.	Mental Health Access Line	1800 011 511

DESCRIPTION OF PRESENTING ISSUE(S): What are the patient's current mental health issues?

MENTAL HEALTH HISTORY/PREVIOUS TREATMENT:	**FAMILY HISTORY OF MENTAL ILLNESS**

SOCIAL HISTORY: Including alcohol or other substance use, current relationships, employment

RELEVANT MEDICAL CONDITIONS/INVESTIGATIONS/ALLERGIES:

CURRENT MEDICATIONS:		**ICD – 10 Provisional Diagnosis**	
☐ Antipsychotics	☐ Anxiolytics	☐ Alcohol & Drug use Disorder	
☐ Hypnotics and Sedatives	☐ Antidepressants	☐ Psychotic Disorder	☐ Depression
☐ Psychostimulants and Nootropics		☐ Anxiety Disorder	☐ Other:
		☐ Unexplained Somatic Disorder	☐ Unknown

MENTAL STATE EXAMINATION:			
Appearance and Behaviour		Mood	
Thinking		Affect	
Perception		Sleep	
Anhedonia		Appetite	
Attention/Concentration		Motivation/Energy	
Memory		Judgement/Insight	
Orientation		Speech	

MANDATORY RISK ASSESSMENT: If answer is 'Yes' to plan, intent or risk to others, refer to Mental Health Access Line: **1800 011 511**			
Suicidal Thoughts	☐ Yes ☐ No	Suicidal Intent	☐ Yes ☐ No
Current Plan (relates to suicide Intent)	☐ Yes ☐ No	Risk to Others	☐ Yes ☐ No
DIAGNOSIS:			

GP MENTAL HEALTH TREATMENT PLAN (MHTP) - PATIENT ASSESSMENT (MBS ITEM NUMBER 2700/2701 OR 2715/2717)			
GP Name		Practice Name	
GP or practice email			
PATIENT NAME		**DATE OF BIRTH**	/ /

PATIENT NEEDS/MAIN ISSUES:	**GOALS:** Record the Mental Health goals agreed to by the patient and GP and any actions the patient will need to take.	**TREATMENTS:** Treatments, actions and support services to achieve patient goals.	**REFERRALS:** Referrals to be provided by GP, as required. The need for further sessions to be reviewed after the initial six sessions

CRISIS/RELAPSE: Note the arrangements for crisis intervention and/or relapse prevention plan

APPROPRIATE PSYCHO-EDUCATION PROVIDED:	☐ Yes ☐ No
AGREED DATE FOR REVIEW: 4 weeks to 6 months after completion of initial MHTP	/ /

PATIENT PREFERRED PSS PROVIDER NAME: (subject to availability and may be left blank) Directory available at https://www.cesphn.org.au/programs/pss

1.	
2.	

If the preferred provider is not available, do you consent to us allocating to an alternative provider? ☐ Yes ☐ No

For referral information or support please contact CESPHN Mental Health Intake on: Phone 1300 170 554
For more information on the PSS Program visit: https://www.cesphn.org.au/programs/pss