



GP INITIAL CHILD TREATMENT PLAN

Psychological Support Services (PSS)

MBS Item: 36 (20+ mins) / MBS Item: 44 (40+ mins)

MBS Item: 2700/ 2701 or 2715/2717 (only to be used if there is a formal Mental Health Diagnosis)

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: CESPNNMH

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 the below eligibility:

Program Eligibility (please check each item - patient must meet each criteria below to be referred)

- Child lives or goes to school in the Central and Eastern Sydney region
- Child is not currently experiencing domestic violence (if so, a mandatory report must be made) and is not involved in any family law or child protection matters
- Child is experiencing, or at risk of developing mild to moderate childhood mental, emotional or behavioural concerns
- Child would benefit from short term psychological intervention
- Child is aged 0 – 12 years old and under, who have not yet graduated from primary school

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

GP DETAILS

GP Name		Practice Name	
Practice postcode		Practice phone	Practice fax
GP or practice email			

*** please note that if an e-mail address is not provided you will not receive referral confirmation.

CHILD DETAILS

First Name		Last Name	
Date of Birth		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Address			
Suburb		Postcode	
Healthcare Card	<input type="checkbox"/> Yes <input type="checkbox"/> No	NDIS Participation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Aboriginal and/or Torres Strait Islander	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Neither <input type="checkbox"/> Unknown		

Country of Birth		Cultural Identity	
Main language spoken at home			
Proficiency in spoken English	<input type="checkbox"/> Very Well <input type="checkbox"/> Well <input type="checkbox"/> Not Well <input type="checkbox"/> Not at All		
PARENT/CARER DETAILS			
First Name		Last Name	
Phone 1		Phone 2	
Relationship			
GP CHILD TREATMENT PLAN (MBS Item: 36 (20+ mins) / MBS Item: 44 (40+ mins))			
PATIENT NAME		DATE OF BIRTH	/ /
DESCRIPTION OF PRESENTING ISSUE(S): Provide a brief description of the child's difficulties and reason/s for referral (e.g. Psychological/emotional/behavioural/physical problems, learning difficulties, developmental issues, social or peer issues, family difficulties/attachment, and/or other)			
MEDICAL AND DEVELOPMENTAL HISTORY: Provide a summary of the child's previous physical and mental health history (including any previous diagnoses and developmental issues/delays)			
FAMILY MEDICAL HISTORY: List any serious physical or mental health conditions that family members or relatives are known to have			
MEDICATIONS:		ALLERGIES:	
PLEASE PROVIDE INFORMATION RELATING TO THE AREAS OF PSYCHO/SOCIAL FUNCTIONING BELOW:			
HOME AND FAMILY: List issues re living arrangements, number of siblings, changes of living, transience, parental separation, custody issues, supervision, out of home care, sibling aggression			
NAME OF SCHOOL:		GRADE:	
LEARNING ISSUES: Consider: literacy, numeracy, attention/concentration, achievement of potential		SOCIAL/BEHAVIOURAL ISSUES: Consider peer relationships, social skills, bullying, aggression, attendance, conduct problems	

EATING, EXERCISE, SLEEP: Consider nutrition, eating patterns, weight gain/loss, exercise, fitness, energy, sleep

SAFETY: Consider immunisation, domestic violence, bullying, abuse, traumatic experiences, risky behaviour, drug/alcohol use, cigarettes, caffeine

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 risk is high please refer to the Mental Health Access Line on: **1800 011 511**

Suicidal thoughts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicidal intent	<input type="checkbox"/> Yes <input type="checkbox"/> No
Current plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	Risk of harm from others	<input type="checkbox"/> Yes <input type="checkbox"/> No
Risk of non-suicidal self-harm	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other child protection concerns	<input type="checkbox"/> Yes <input type="checkbox"/> No

If answer is "yes" please explain:

OUTCOME TOOL USED:

OUTCOME TOOL RESULT(S):

PROBLEM(S)/ACTION(S)

PROBLEM

ACTION

EMERGENCY CARE PLAN

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

AGREED DATE FOR REVIEW: 4 weeks to 6 months after completion of initial plan		/ /
PARENT/CARER PREFERRED PSS PROVIDER NAME: (subject to availability and may be left blank) Directory available at https://www.cesphn.org.au/PSS		
1.		
2.		
If the preferred provider is not available, do you consent to us allocating to an alternative provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		

PARENT/CARER CONSENT: <i>Referral cannot proceed without parent/carer consent</i>		
<input type="checkbox"/> Referring GP confirms that the parent/carer understands and consents to the following; <ul style="list-style-type: none"> • The above Child Treatment Plan/Review 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 • That the child's de-identified data will be used for reporting and evaluation purposes • 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 <input type="checkbox"/> Yes <input type="checkbox"/> No 		
GP SIGNATURE:		DATE: / /

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>