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 170 554 or HEALTHLINK ID: CESPHNMH

DATE OF REFERRAL	/ /

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 has completed all Medicare rebated psychological service sessions under Better Access
☐ Child is unable to access other available services, including Better Access
☐ 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 emotional or behavioral concerns
☐ Child would benefit from short term psychological intervention
☐ Child is aged 0 – 12 years old and under

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	☐ Male ☐ Female ☐ Other
Address			
Suburb		Postcode	
Healthcare Card	☐ Yes ☐ No	NDIS Participation	☐ Yes ☐ No
Aboriginal and/or Torres Strait Islander	☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Unknown		
Country of Birth		Cultural Identity	
Main language spoken at home			
Proficiency in spoken English	☐ Very Well ☐ Well ☐ Not Well ☐ Not at All		

PARENT/CARER DETAILS			
First Name		Last Name	
Phone 1		Phone 2	
Relationship			

For referral information or support please contact CESPHN Mental Health Intake on: Phone 1300 170 554

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	

RISK ASSESSMENT: If risk is high please refer to the Mental Health Access Line on: **1800 011 511**			
Suicidal thoughts	☐ Yes ☐ No	Suicidal intent	☐ Yes ☐ No
Current plan	☐ Yes ☐ No	Risk of harm from others	☐ Yes ☐ No
Risk of non-suicidal self-harm	☐ Yes ☐ No	Other child protection concerns	☐ Yes ☐ 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.	

PARENT/CARER CONSENT: *Referral cannot proceed without parent/carer consent*

☐ Referring GP confirms that the parent/carer undersdands and consents to the following;

- 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 experince of care survey ☐Yes ☐No

GP SIGNATURE:		**DATE:**	/ /

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For more information on the PSS Program visit: https://www.cesphn.org.au/programs/pss