GP REVIEW REFERRAL

Psychological Support Services (PSS)

SUBMIT COMPLETED REFERRALS via SECURE FAX: 1300 112 489 or HEALTHLINK ID: CESPHNMH
For referral information or support please contact CESPHN Mental Health Intake on: Phone 1300 170 554

GP MENTAL HEALTH TREATMENT PLAN (MHTP) – REVIEW (MBS ITEM NUMBER 2712)

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

PATIENT NAME		**DATE OF BIRTH**	/ /
DATE OF REVIEW	/ /	**Assessment TOTAL SCORE**	

CURRENT PATIENT NEEDS/MAIN ISSUES:	**REVISED OR OUTSTANDING GOALS:**	**CURRENT TREATMENTS:**	**ANY NEW REFERRALS:**

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

CRISIS/RELAPSE: Note the arrangements for crisis intervention and/or relapse prevention plan if YES is ticked in any of the Risk Assessment

AGREED DATE FOR REVIEW: at least 3 months after the first review	/ /

PATIENT CONSENT: *Referral cannot proceed without patient consent*

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

- The above 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 appoinment
- That they may be contacted by CESPHN or its representative to complete a client experince of care survey ☐ Yes ☐ No

GP SIGNATURE:		**DATE:**	/ /