GP REVIEW CHILD TREATMENT PLAN
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 CHILD TREATMENT PLAN – REVIEW (MBS Item: 36 (20+ mins) / MBS Item: 44 (40+ mins)

GP Name		Practice Name	
Practice postcode		Practice fax	
GP or practice email		Practice phone	
PATIENT NAME		**DATE OF BIRTH**	/ /
DATE OF REVIEW	/ /	**OUTCOME TOOL RESULT(S)**	

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

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

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

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

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			
GP SIGNATURE:		**DATE:**	/ /