



# 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**

<b>SUBMIT COMPLETED REFERRALS via SECURE FAX: 1300 112 489 or HEALTHLINK ID: CESPNNMH</b>					
<b>DATE OF REFERRAL</b>					
<b>Program Eligibility (please check each item - patient must meet each criteria below to be referred)</b>					
<input type="checkbox"/> Child lives or goes to school in the Central and Eastern Sydney region					
<input type="checkbox"/> Child has NOT accessed Medicare rebated psychological services this <u>calendar year</u> under Better Access					
<input type="checkbox"/> Child is unable to access other available services, including Better Access					
<input type="checkbox"/> 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					
<input type="checkbox"/> Child is experiencing, or at risk of developing mild to moderate childhood emotional or behavioral concerns					
<input type="checkbox"/> Child would benefit from short term psychological intervention					
<input type="checkbox"/> Child is aged 0 – 12 years old and under					
<b>GP DETAILS</b>					
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.					
<b>CHILD DETAILS</b>					
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			
<b>PARENT/CARER DETAILS</b>					
First Name		Last Name			
Phone 1		Phone 2			
Relationship					

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

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

<b>PATIENT NAME</b>		<b>DATE OF BIRTH</b>	
---------------------	--	----------------------	--

**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 brief 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

--

<b>MENTAL STATE EXAMINATION:</b>			
Appearance and Behaviour		Mood	
Thinking		Affect	
Perception		Sleep	
Anhedonia		Appetite	
Attention/Concentration		Motivation/Energy	
Memory		Judgement/Insight	
Orientation		Speech	
<b>RISK ASSESSMENT:</b> If risk is high please refer to the Mental Health Access Line on: <b>1800 011 511</b>			
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
<b>If answer is "yes" please explain:</b>			
<b>OUTCOME TOOL USED:</b>		<b>OUTCOME TOOL RESULT(S):</b>	
<b>PROBLEM(S)/ACTION(S)</b>			
<b>PROBLEM</b>		<b>ACTION</b>	
<b>EMERGENCY CARE PLAN</b>			
1.		<b>PHONE:</b>	
2.		<b>PHONE:</b>	
3.	Mental Health Access Line	<b>PHONE:</b>	1800 011 511
<b>AGREED DATE FOR REVIEW:</b> 4 weeks to 6 months after completion of initial plan			
<b>PARENT/CARER PREFERRED PSS PROVIDER NAME: (subject to availability and may be left blank)</b> Directory available at <a href="https://www.cesphn.org.au/PSS">https://www.cesphn.org.au/PSS</a>			
1.			
2.			
<b>PARENT/CARER CONSENT:</b> <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"> <li>The above Child Treatment Plan/Review and agrees to the outlined goals and treatments</li> <li>That CESPHN collects and shares information within the requirements of the Privacy Act 1988, with the PSS Provider Organisation and treating Mental Health Professional</li> <li>That the child's de-identified data will be used for reporting and evaluation purposes</li> <li>That they will be contact by the allocated PSS Provider Organisation or Mental Health Professional to arrange an appointment</li> <li>That they may be contacted by CESPHN or its representative to complete a client experience of care survey</li> </ul>			
<b>GP SIGNATURE:</b>		<b>DATE:</b>	