GP REVIEW CHILD TREATMENT PLAN
Psychological Support Services (PSS)

SUBMIT COMPLETED REFERRALS via SECURE FAX: 1300 112 489 or HEALTHLINK ID: CESPHNMH

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

PATIENT NAME				DATE OF BIRTH	
DATE OF REVIEW		OUTCOME TOOL USED		OUTCOME TOOL RESULT(S)	

PROBLEM(S)/ACTION(S)

PROBLEM	ACTION

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	

PATIENT/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 understands and concents 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 contact 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

GP SIGNATURE:		DATE:	