GP INITIAL REFERRAL AND MHTP
Psychological Support Services (PSS)

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 112 489 or HEALTHLINK ID: CESPHNMH

DATE OF REFERRAL	/ /

Program Eligibility ***(please check each item - patient must meet each criteria below to be referred)***

☐ Patient lives, works or goes to school in the Central and Eastern Sydney region
☐ Patient has completed all Medicare rebated psychological service sessions under Better Access
☐ Patient is unable to access other available services, including Better Access
☐ Patient is experiencing mild to moderate mental illness, or severe mental illness and would benefit from short term psychological intervention
☐ Patient is not better suited to a crisis or specialist domestic violence services and is not involved in court or insurance matters

Underserviced Group ***(Please tick the underserviced (vulnerable) group that best fits your individual: Pick ONE only.***

☐ Child (0 – 12 years old and under)
☐ Young person (12 – 25 years old) ☐Headspace
☐ Individuals experiencing perinatal depression
Baby's Date of Birth _____
☐ Other underservices groups, includes:
- Adult who is unable to access Better Access due to financial or other constraints
- Adult who is, or at risk of becoming homeless
- Adult who is living within the following Local Government Areas: *Bayside, Georges River, Canterbury City, Strathfield*

☐ Has attempted, or is at risk of suicide, or self-harm (non-acute)
☐ Culturally and Linguistically Diverse (CALD) background
☐ Lesbian, Gay, Bisexual, Transgender, Queer, Intersex (LGBTQI)
☐ Identifies as Aboriginal and/or Torres Strait Islander (K5)

GP DETAILS					
GP Name		Practice Name			
Practice postcode		Practice phone		Practice fax	
GP or practice email (For all correspondence)					
**** please note that if an e-mail address is not provided you will not receive referral confirmation.*					

PATIENT DETAILS			
First Name		Last Name	
Date of Birth			
Marital Status	☐ Never Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Married/De facto		
Current Gender Identity	☐ Female ☐ Male ☐ Non-binary ☐ Not Stated ☐Transgender Female/Male-Female ☐ Transgender Male/Female-Male		
Address			
Suburb		Postcode	
Phone 1		Phone 2	
Healthcare Card	☐ Yes ☐ No	NDIS Participation	☐ Yes ☐ No
Country of Birth		Cultural Identity	
Aboriginal or Torres Strait Islander	☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Unknown		
Main language spoken at home			
Proficiency in spoken English	☐ Very Well ☐ Well ☐ Not Well ☐ Not at All		

MENTAL HEALTH SELF-ASSESSMENT TOOL (to be completed by patients over 16 years old)							
Assessment Tool Used: (e.g. DASS, K10) **The K5 must be used when referring patients who identify as Aboriginal or Torres Strait Islander**							
Total Score:							
Additional Questions	In addition to the assessment tool used, please ask patient to complete the following functionality questions.						
In the last 4 weeks:							
1	how many days were you totally unable to work, study or manage your day to day activities because of these feelings?	(Number of Days)					
2	aside from those days, in the past four weeks, how many days were you able to work or study or manage your day to day activities, but had to cut down on what you did because of these feelings?	(Number of Days)					
3	how many times have you seen a doctor or any other health professional about these feelings?	(Number of Consultations)					
		None of the time	**A little of the time**	**Some of the time**	**Most of the time**	**All of the time**	**Not stated / Missing**
4	how often have physical health problems been the main cause of these feelings?	☐	☐	☐	☐	☐	☐

CO-MORBID ISSUES

Please indicate if the client has any of the below co-morbid issues

☐ Chronic physical illness
☐ Drug and alcohol issues
☐ Intellectual disability
☐ Psychiatric co-morbidity
☐ Personality issues
☐ Psychosocial stressors
☐ Suicidality

PATIENT CONSENT: *Referral cannot proceed without patient consent*

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

- The attached 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:**	/ /

GP MENTAL HEALTH TREATMENT PLAN (MHTP) - PATIENT ASSESSMENT (MBS ITEM NUMBER 2700/2701 OR 2715/2717)			
PATIENT NAME		**DATE OF BIRTH**	/ /

CARER DETAILS AND/OR EMERGENCY CONTACT(S):		
	NAME	**PHONE**
1.		
2.		
3.	Mental Health Access Line	1800 011 511

DESCRIPTION OF PRESENTING ISSUE(S): What are the patient's current mental health issues?

MENTAL HEALTH HISTORY/PREVIOUS TREATMENT:	**FAMILY HISTORY OF MENTAL ILLNESS**

SOCIAL HISTORY: Including alcohol or other substance use, current relationships, employment

RELEVANT MEDICAL CONDITIONS/INVESTIGATIONS/ALLERGIES:

CURRENT MEDICATIONS:		**ICD – 10 Provisional Diagnosis**	
☐ Antipsychotics	☐ Anxiolytics	☐ Alcohol & Drug use Disorder	
☐ Hypnotics and Sedatives	☐ Antidepressants	☐ Psychotic Disorder	☐ Depression
☐ Psychostimulants and Nootropics		☐ Anxiety Disorder	☐ Other:
		☐ Unexplained Somatic Disorder	☐ Unknown

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 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

DIAGNOSIS:

GP MENTAL HEALTH TREATMENT PLAN (MHTP) - PATIENT ASSESSMENT (MBS ITEM NUMBER 2700/2701 OR 2715/2717)			
GP Name		Practice Name	
GP or practice email			

PATIENT NAME		**DATE OF BIRTH**	/ /

PATIENT NEEDS/MAIN ISSUES:	**GOALS:** Record the Mental Health goals agreed to by the patient and GP and any actions the patient will need to take.	**TREATMENTS:** Treatments, actions and support services to achieve patient goals.	**REFERRALS:** Referrals to be provided by GP, as required. The need for further sessions to be reviewed after the initial six sessions

CRISIS/RELAPSE: Note the arrangements for crisis intervention and/or relapse prevention plan	
APPROPRIATE PSYCHO-EDUCATION PROVIDED:	☐ Yes ☐ No
AGREED DATE FOR REVIEW: 4 weeks to 6 months after completion of initial MHTP	/ /

PATIENT PREFERRED PSS PROVIDER NAME: (subject to availability and may be left blank) Directory available at https://www.cesphn.org.au/programs/pss	
1.	
2.	

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

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