GP REVIEW REFERRAL

Psychological Support Services (PSS)

SUBMIT COMPLETED REFERRALS via SECURE FAX: 1300 112 489 or HEALTHLINK ID: CESPHNMH			
GP MENTAL HEALTH TREATMENT PLAN (MHTP) – REVIEW (MBS ITEM NUMBER 2712)			
PATIENT NAME		**DATE OF BIRTH**	
DATE OF REVIEW		**K10+ TOTAL SCORE**	

PATIENT NEEDS/MAIN ISSUES:	**GOALS:**	**TREATMENTS:**	**REFERRALS:**
CRISIS/RELAPSE: Note the arrangements for crisis intervention and/or relapse prevention plan			
APPROPRIATE PSYCHO-EDUCATION PROVIDED:			☐ Yes ☐ No

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

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

PATIENT CONSENT: *Referral cannot proceed without patient consent*

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

- The above Mental Health 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 their 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:**	