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Referral Form

Name: _____ DOB: _____

Contact Details: _____

Reason for Referral:

- | | |
|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mood disorder |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> OCD |
| <input type="checkbox"/> PTSD and trauma | <input type="checkbox"/> Phobias (Fears) |
| <input type="checkbox"/> Insomnia, Sleep issues | <input type="checkbox"/> Irritable bowel disorder |
| <input type="checkbox"/> Behavioural difficulties | <input type="checkbox"/> Eating and body image issues |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Relationships counselling |
| <input type="checkbox"/> Couples Therapy | <input type="checkbox"/> Dispute Mediation |
| <input type="checkbox"/> Anger management issues | <input type="checkbox"/> Grief, bereavement and loss |
| <input type="checkbox"/> Self esteem and self development | <input type="checkbox"/> Life transition & adjustment issues |
| <input type="checkbox"/> Workplace bullying | <input type="checkbox"/> Work Stress/ Stress management |
| <input type="checkbox"/> Workplace/Executive Coaching | <input type="checkbox"/> Coping with injury or illness |
| <input type="checkbox"/> Addiction/Substance abuse | <input type="checkbox"/> Pain Management |
| <input type="checkbox"/> MVA or personal injury | <input type="checkbox"/> Workers Compensation |
| <input type="checkbox"/> Other _____ | |

Comments:

Referring Doctor: _____

Signature: _____ Date: _____

PATIENT ASSESSMENT

Patient's Name		Date of Birth	
Address		Phone	
Carer details and/or emergency contact		Other care plan e.g.GPMP / TCA	
GP Name / Practice			
AHP or nurse currently involved in patient care		Medical Records No.	
PATIENT CONSENT Patient has agreed to GP Mental Health Care Plan service	(signature)		
PRESENTING ISSUE(S) What are the patient's current mental health issues			
PATIENT HISTORY Record relevant <ul style="list-style-type: none"> • biological • psychological and • social history including any • family history of mental disorders and any relevant • substance abuse or • physical health problems 			
MEDICATIONS (attach information if required)			
ALLERGIES			
OTHER RELEVANT INFORMATION			
RESULTS OF MENTAL STATE EXAMINATION Record after patient has been examined (refer to table on last page of template)			
RISKS AND CO-MORBIDITIES Note any associated risks and co-morbidities including suicidal tendencies and risks to others			
OUTCOME TOOL USED		RESULTS	
DIAGNOSIS			

GP MENTAL HEALTH CARE PLAN (MBS ITEM NUMBER 2710)

PATIENT PLAN

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 Note: Referrals to be provided by GP, as required, in up to two groups of six sessions. The need for the second group of sessions to be reviewed after the initial six sessions.
CRISIS / RELAPSE If required, note the arrangements for crisis intervention and/or relapse prevention.			
APPROPRIATE PSYCHO-EDUCATION PROVIDED		PLAN ADDED TO THE PATIENT'S RECORDS	COPY (OR PARTS) OF THE PLAN OFFERED TO OTHER PROVIDERS
COMPLETING THE PLAN On completion of the plan, the GP is to record that s/he has discussed with the patient: -the assessment; -all aspects of the plan and the agreed date for review; and -offered a copy of the plan to the patient and/or their carer (if agreed by patient)			
DATE PLAN COMPLETED:		REVIEW DATE: (initial review 4 weeks to 6 months after completion of plan)	
REVIEW - MBS ITEM 2712 REVIEW COMMENTS (Progress on actions and tasks) Note: If required, a separate form may be used for the Review.		OUTCOME TOOL RESULTS ON REVIEW	

Mental State Examination (complete relevant aspects):

Appearance & General Behaviour	
Mood (depressed/ labile)	
Thinking (content/rate/disturbance)	
Affect (flat/blunted)	
Perception (hallucinations etc)	
Appetite (disturbed eating patterns)	
Attention/concentration	
Motivation/energy	
Memory (short and long term)	
Insight	
Anxiety symptoms (physical and emotional)	
Orientation (time/place/ person)	
Sleep (initial insomnia/ early morning wakening)	
Cognition (level of consciousness/delirium/ intelligence)	
Judgment (ability to make rational decisions)	