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**

SUBMIT COMPLETED REFERRALS via SECURE FAX: (02) 9330 9988 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 NOT accessed Medicare rebated psychological services this calendar year under Better Access
☐ Patient is unable to access other available services, including Better Access
☐ Patient is experiencing mild to moderate mental illness
☐ Patient 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 check at least one item - patient must meet at least one criteria below to be referred)***

☐ Child (0 – 12 years old and under)
☐ Young person (12 – 25 years old)
☐ Women experiencing perinatal depression
☐ Has attempted, or is at risk of suicide, or self-harm (non-acute)
☐ Culturally and Linguistically Diverse (CALD) background
☐ Identifies as Aboriginal ☐ Identifies as Torres Strait Islander
☐ Other underserviced 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*

GP DETAILS

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.*

PATIENT DETAILS

First Name		Last Name	
Date of Birth			
Marital Status	☐ Never Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Married/De facto		
Current Gender Identity	☐ Male ☐ Female ☐ Non-binary ☐ Different Identity		
Address			
Suburb		Postcode	
Phone 1		Phone 2	
Healthcare Card	☐ Yes ☐ No	NDIS Participation	☐ Yes ☐ No
Country of Birth		Cultural Identity	
Main language spoken at home			
Proficiency in spoken English	☐ Very Well ☐ Well ☐ Not Well ☐ Not at All		

For referral information or support please contact CESPHN Mental Health Intake on: Phone (02) 9330 9999

MENTAL HEALTH SELF-ASSESSMENT TOOL (to be completed by patients over 16 years old)

K10+ ***(please note, this is an updated version of the K10 - questions 11-14 are excluded from total score)***

	In the last 4 weeks:	**None of the time**	**A little of the time**	**Some of the time**	**Most of the time**	**All of the time**	**Not stated / Missing**
1	about how often did you feel tired out for no good reason?	☐	☐	☐	☐	☐	☐
2	about how often did you feel nervous?	☐	☐	☐	☐	☐	☐
3	about how often did you feel so nervous that nothing could calm you down?	☐	☐	☐	☐	☐	☐
4	about how often did you feel hopeless?	☐	☐	☐	☐	☐	☐
5	about how often did you feel restless or fidgety?	☐	☐	☐	☐	☐	☐
6	about how often did you feel so restless you could not sit still?	☐	☐	☐	☐	☐	☐
7	about how often did you feel depressed?	☐	☐	☐	☐	☐	☐
8	about how often did you feel that everything was an effort?	☐	☐	☐	☐	☐	☐
9	about how often did you feel so sad that nothing could cheer you up?	☐	☐	☐	☐	☐	☐
10	about how often did you feel worthless?	☐	☐	☐	☐	☐	☐
	TOTAL SCORE						
11	how many days were you totally unable to work, study or manage your day to day activities because of these feelings?	(Number of Days)					
12	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)					
13	how many times have you seen a doctor or any other health professional about these feelings?	(Number of Consultations)					
14	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

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)			
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/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:**	