



GP REVIEW REFERRAL

Psychological Support Services (PSS)

SUBMIT COMPLETED REFERRALS via SECURE FAX: (02) 9330 9988 or HEALTHLINK ID: CESPHEMH			
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:			<input type="checkbox"/> Yes <input type="checkbox"/> 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: <i>Referral cannot proceed without patient consent</i>			
<input type="checkbox"/> Referring GP confirms that the patient understands and consents to the following; <ul style="list-style-type: none"> • The above Mental Health Treatment Plan/Review and agrees to the outlined goals and treatments • That CESPHEM 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 appointment • That they may be contacted by CESPHEM or its representative to complete a client experience of care survey 			
GP SIGNATURE:		DATE:	