

**ST GEORGE ACCESS TO ALLIED PSYCHOLOGICAL SERVICES (ATAPS)
REFERRAL FORM**

GP name		GP postcode	
GP phone		GP fax	
Patient name		Date of birth	
Address		Postcode	
Phone		Mobile	
			Gender
Date of Assessment		Outcome Tool	
			Results
Language spoken at home	English <input type="checkbox"/> Italian <input type="checkbox"/> Cantonese <input type="checkbox"/> Greek <input type="checkbox"/> Mandarin <input type="checkbox"/> Arabic <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other <input type="checkbox"/> please specify:		
How well does the person speak English	Very well <input type="checkbox"/> Well <input type="checkbox"/> Not well <input type="checkbox"/> Not at all <input type="checkbox"/>		
Is the person of Aboriginal or Torres Strait Islander	No <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Unknown <input type="checkbox"/>		
Highest education level completed	Primary or below <input type="checkbox"/> Secondary Yr 10 or equivalent <input type="checkbox"/> Secondary Yr 11 or equivalent <input type="checkbox"/> Secondary Yr 12 or equivalent <input type="checkbox"/> Tertiary <input type="checkbox"/>		
Does the person live alone	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>		
Is the person a low income earner (<\$30,000 single income & <\$60,000 combined family income)	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>		
Has the person ever received specialist mental health care	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>		

Fax to St George Division of General Practice on 9585 2144

Andrew Szemenyei (children 0-12 yrs and Perinatal)

Belinda Ivanovski (for young people 12-25yrs)

Fernando Gomez (for adults 18yrs+)

OR

Fax to Transcultural Mental Health Centre on 9840 4180

To be seen by a bi-lingual counsellor

Language requested:

Office use only:

Patient ID:, ATAPS or Perinatal , Number of sessions completed:, Date minimum data set entered:

Conclusion: Treatment completed Patient could not be contacted Patient refused treatment
 Patient referred elsewhere Treatment incomplete but referral closed

GP MENTAL HEALTH TREATMENT PLAN (MBS ITEM NUMBER 2710)

PATIENT ASSESSMENT

Patient Name		Date of Birth	
Address		Phone	
Date of Assessment	Outcome Tool	Result	
Description of Presenting Complaint / Problem			
Mental Health History / Treatment		Family History of Mental Illness	
Social History (including substance, or other, abuse) including Current Relationships, Job			
Is the person receiving psychotropic medication		Relevant Medical Conditions / Investigations / Allergies	
Benzodiazepines & anxiolytics <input type="checkbox"/> Antidepressants <input type="checkbox"/> Phenothiazine's & major tranquilisers <input type="checkbox"/> Mood stabilisers <input type="checkbox"/> Other <input type="checkbox"/>			
Mental Status Examination <i>(Please indicate relevant details)</i>			
Appearance and Behaviour		Mood	
Thinking		Affect	
Perception		Sleep	
Anhedonia		Appetite	
Attention / Concentration		Motivation / Energy	
Memory		Judgement / Insight	
Orientation		Speech	
Risk Assessment <i>(if answer is Yes to plan, intent or risk to others refer to St George Mental Health Team, on 9113 4444)</i>			
Suicidal thoughts	Yes <input type="checkbox"/> No <input type="checkbox"/>	Suicidal intent	Yes <input type="checkbox"/> No <input type="checkbox"/>
Current plan	Yes <input type="checkbox"/> No <input type="checkbox"/>	Risk to Others	Yes <input type="checkbox"/> No <input type="checkbox"/>
ICD – 10 Provisional Diagnosis		Allied Health Referral Plan	
F1 Alcohol & Drug Use disorder <input type="checkbox"/> F2 Psychotic Disorder <input type="checkbox"/> F3 Depression <input type="checkbox"/> F4 Anxiety Disorder <input type="checkbox"/> F5 Unexplained Somatic Disorder <input type="checkbox"/> Other / Unknown:		Diagnostic Assessment <input type="checkbox"/> Psycho education <input type="checkbox"/> CBT <input type="checkbox"/> Interpersonal Therapy <input type="checkbox"/>	

**GP MENTAL HEALTH CARE PLAN (MBS ITEM NUMBER 2710) &
REVIEW (MBS ITEM NUMBER 2712)**

Patient Name		Date of Birth	
Actual Date of Mental Health Review		Outcome Tool Result at Review	

PATIENT NEEDS/ MAIN ISSUES	GOALS (eg. Reduce symptoms, improve functioning)	ACTION / TASK (Referral to Allied Health, medication, engagement of family/other supports)	REVIEW OUTCOME (Impact of action/ task on problem)
1.			
2.			
3.			

Relapse Prevention Plan (<i>Re-examine at Review Consultation.</i>)

Emergency Care (<i>eg Family contact person / details</i>)
1
2
3 St George Mental Health Service Phone 9113 4444

Additional Notes

Has a copy of the MH Plan been given to the Patient?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Proposed date for Mental Health Review (1 – 6 months after MH Plan adopted)		

The following section to be signed by patient and GP:

<i>I understand the above Mental Health Plan and agree to the outlined goals / actions</i>	
Patient Signature:	GP Signature: