

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 9 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"/>		
Perinatal referrals	Child birth date _____ or Child due date _____		

Fax to St George Division of General Practice on 9585 2144

Fernando Gomez (for adults 18yrs+) Adriana Zapata-Delgado (for adults & perinatal) Belinda Ivanovski (young people 13-15yrs) Cate Arciuli (children & young people 5-25yrs)

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 Perinatal Child Young Person YP Homeless 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 2700, 2701 OR 2715, 2717) &
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 (*Re-examine at Review Consultation.*)

Emergency Care (*eg Family contact person / details*)

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 understand the above Mental Health Plan and agree to the outlined goals / actions

Patient Signature:	GP Signature:
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