Mental Health Referral Form

Secure Fax: **(02) 8208 9941** or HealthLink EDI: **wntwstmh**

Patient Information:			
Full Name:	Miss Ashley Trethowan	**D.O.B:**	22/10/2001
Address:	40 Buckingham St	**Suburb:** Pitt Town	**Postcode:** 2756
Gender:	☐ M ☑ F ☐ Other:	**Country of Birth:**	AUSTRALIA
Medicare Number:	2546066454	**Mobile Number:**	0424 188 449
Main Language spoken at home:	☑ English ☐ Other (please specify):		
Spoken English Level:	☑ Very Well ☐ Well ☐ Not Well ☐ Not at all	☐ Interpreter Required	
Aboriginal and/or Torres Strait Islander:	☑ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Both ☐ Unknown		
Marital Status:	☑ Never married ☐ Married/De facto ☐ Widowed ☐ Divorced ☐ Separated ☐ Unknown		
Homelessness:	☑ Stable housing ☐ Short-term/emergency accommodation ☐ Sleeping rough		
Labour Force Status:	☑ Employed ☐ Unemployed ☐ Not in the labour force ☐ Unknown		
Employment type:	☑ Full time ☐ Part time/Casual ☐ Not applicable ☐ Unknown		
Source of income:	☑ Paid employment ☐ Nil income ☐ Disability support pension ☐ Other pension ☐ Compensation payments ☐ Other (super, investments etc) ☐ Unknown		
Health Care Card:	☐ No ☑Yes Number: 280589715V		
Financial Hardship:	☑ No ☐ Yes		
NDIS Registered:	☑ No ☐Yes Number:		

Mental Health Presentations

Presenting Issues ANXIETY EXACERBATION, DEALING WITH PREVIOUS TRAUMA

Principal Diagnosis

Anxiety Disorders:	☐ OCD	☑ Adjustment disorder	☐ Alcohol dependence
☐ Panic disorder	Depressive Disorders:	☐ Oppositional defiant	☐ Drug dependence
☐ Agoraphobia	☐ Major depression	☐ Personality disorder	☐ Schizophrenia
☐ Social phobia	☐ Depressive symptoms	☐ Conduct disorder	☐ Other: _
☐ Generalised anxiety	☐ Bipolar Disorder	☐ Complex PTSD	

Severity *(please tick one)*: ☐ Mild ☑ Moderate ☐ Severe Acute ☐ Severe Complex

Psychotropic Medication *(please tick all that apply)*

☐ None	☐ Antidepressants	
☐ Hypnotics & sedatives	☐ Antipsychotics	
☐ Psychostimulants & nootropics	☑ Anxiolytics	

Outcome Tool Score: *(required for referral to be approved)* ☑ K10: / 50 Other: _

Previous Mental or Physical Health History or Treatment:

Priority Group

☐ Child (0-12 years) ☑ Young Adult (13-25 years) ☐ CALD ☐ Aboriginal and/or Torres Strait Islander
☐ Refugee/Asylum Seeker ☐ Severe & Complex Mental Illness ☐ Perinatal ☐ LGBTIQ ☐ Elderly

Is this Person currently at high risk of suicide? ☐ Yes ☑ No

Treatments

Referred for which strategies	☑ Psychological therapy	☐ Psychiatric services
	☐ Suicide prevention service	☐ Other:
Preferred WentWest Provider	☑ Yes (Provider Name): KELLI-MARIE MOSES ☐ No preference (provider/service will be assigned by WentWest)	
Preferred Modality:	☑ Face -to-face ☐Telehealth (Note: first preference may not be guaranteed)	

Additional Information e.g. anger, self-harm, grief

Referrer Details

Full Name:	LOURDES JOY ELPEDES-BOLINA	Profession:	GP
Organisation type:	MEDICLINIC ROUSE HILL	Phone Number:	02 88830045
Address:	SHOP 13 ROUSE HILL VILLAGE CENTRE, 18-24 ADELPHI ST ROUSE HILL 2155	Fax Number:	02 88830042
		HealthLink EDI	MEDROUSE

*****Consent: Patient or Parent/Guardian for a Child Must be Completed for the Referral to be Accepted*****

☑ **Referrer confirms that the patient understands and consents to the following:**

1. Understands that the information provided in this referral is required to determine eligibility for services with WentWest.
2. Gives consent for services to be provided by suitable programs, as requested on this referral.
3. Gives permission for the exchange of this information between Health Professional and other agencies for the purpose of coordination of care.
4. Consents to de-identified information to be used for statistical purposes for WentWest and the Department of Health.

Referrer name: LOURDES JOY ELPEDES-BOLINA
(Include name for forms sent via HealthLink)

Referrer signature: ELECTRONICALLY SIGNED

Date: 26/09/2023

Please ensure the following is complete before sending to WentWest

- Medication List and GP Referral Letter for Psychiatry service
- Patient contact information including phone number
- Financial and priority group information including Health Care Card number
- Mental Health Treatment Plan and Outcome Assessment Tool is attached
- Consent section completed above

Send completed form and Mental Health Treatment Plan via:
Secure Fax: **(02) 8208 9941** or HealthLink EDI: **wntwstmh**

Primary Mental Health Care does not routinely accept referrals for the sole purpose of court reports and/or legal documentation.

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NSW 2145

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E mentalhealth@wentwest.com.au
ACN 009 255 106
ABN 80 099 255 106

WENTWEST.COM.AU

Outcomes Tool K10 Form

Name: ASHLEY TRETHOWAN
Date: 26/09/2023
For all questions, please circle the appropriate response.

In the past 4 weeks:	None of the time	A little of the time	Some of the time	Most of the time	All of the time
About how often did you feel tired out for no good reason?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☑
About how often did you feel nervous?	1 ☐	2 ☐	3 ☑	4 ☐	5 ☐
About how often did you feel so nervous that nothing could calm you down?	1 ☐	2 ☑	3 ☐	4 ☐	5 ☐
About how often did you feel hopeless?	1 ☐	2 ☑	3 ☐	4 ☐	5 ☐
About how often did you feel restless or fidgety?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☑
About how often did you feel so restless you could not sit still?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☑
About how often did you feel depressed?	1 ☐	2 ☑	3 ☐	4 ☐	5 ☐
About how often did you feel that everything is an effort?	1 ☐	2 ☐	3 ☑	4 ☐	5 ☐
About how often did you feel so sad that nothing could cheer you up?	1 ☐	2 ☐	3 ☑	4 ☐	5 ☐
About how often did you feel worthless?	1 ☐	2 ☑	3 ☐	4 ☐	5 ☐

Office Use:

K10 Score Total	32	Client ID	

G.P. MENTAL HEALTH TREATMENT PLAN

Date: 26/09/2023

Patient Details:

Pt. Name: Miss Ashley Trethowan	**GP Name:** Dr Lourdes Joy Elpedes-Bolina
Address : 40 Buckingham St Pitt Town 2756	**Surgery:** Aus Healthcare Pty Ltd T/A MediClinic Rouse Hill
Tel No: **Mobile:** 0424 188 449	**Address:** 18-24 ADELPHI ST
Medicare No: 2546066454 **DVA Number:**	**Tel No:** 88830045
DOB: 22/10/2001	**Key Contact:** KYLIE SULLIVAN, MOTHER **Tel No:** 0414 339 014

Does the patient identify as ATSI?: No
Language spoken at home? English
If Other, please specify:
How well does the patient speak English? Well
Does the patient live on her own? No
Is the patient a low income earner? No
What is the highest level of education the patient has completed? Higher Education
Has the patient ever received specialist mental health care before? No

PSYCHIATRIC HISTORY (Previous episodes, previous diagnosis, admissions, orders etc)
CHRONIC ANXIETY

SOCIAL HISTORY (Family, marital etc)
LIVING WITH FATHER

FAMILY HISTORY OF MENTAL ILLNESS
MOTHER, DEPRESSION
AUNT, SEVERE DEPRESSION AND ANXIETY
FATHER, PERSONALITY DISORDER

DRUG & ALCOHOL HISTORY
NIL

EMPLOYMENT HISTORY
EMPLOYED CURRENTLY

MEDICAL HISTORY

04/12/2014	Fractured left wrist, greenstick	
03/2016	Wisdom tooth extraction	
07/04/2016	Encephalitis, viral	
12/04/2016	Left Optic neuritis	
16/11/2016	Left Optic neuritis, resolved	secondary to encephalitis
08/03/2017	Iron deficiency	
02/2018	Low normal iron	
27/09/2019	Low ferritin 13	
26/02/2020	Low ferritin 21, improving	
14/03/2020	Helicobacter pylori breath test negative	
27/05/2020	Low ferritin 17	
15/12/2020	Faecal loading of the ascending colon and the distal sigmoid	
30/11/2021	Vitamin D deficiency 45	
13/04/2022	Low ferritin 26	
30/06/2022	Polycystic ovarian morphology	The ovaries have a polycystic ovarian morphology. Please correlate with the clinical history and the serum biochemistry to confirm the diagnosis of the syndrome as this is a common finding in a patient of this age.
25/07/2023	Low ferritin 10	
25/07/2023	Ct lumbar spine, see report	Very small posterior disc bulges/protrusion at the level of L4/ L5 and L5/S1. There is no central canal stenosis or nerve root impingement.
03/08/2023	Ana ena negative	

03/08/2023 HLA B27 Positive
21/08/2023 Iron infusion

MEDICATIONS

Aropax 20mg Tablet (Paroxetine Hydrochloride)	1 Tablet In the morning with meals.
Ferinject 500mg/10mL Injection (Ferric carboxymaltose)	1 Injection For doctor's use.
Ostelin Vitamin D 1000IU Gel Capsule (Cholecalciferol)	1 Capsule Daily As directed.

Presenting Complaint:

ANXIETY EXACERBATION, PREVIOUS TRAUMA

Precipitating Factors:

Precipitating Factor 1:
Precipitating Factor 2:
Precipitating Factor 3:

Mental State Examination:

APPEARANCE:	Comments/Other
Dress: Neat	
Hygiene: OK	
BEHAVIOUR:	
Psychomotor: Normal	
Communication: Normal	
CONVERSATION:	
Speech: Normal	
AFFECT:	
Mood: Agitated	
PERCEPTION:	
Delusions: Not Present	
Hallucinations: None	
COGNITION:	
Thoughts: Vague	
Thought Flow: Thought Blocking	

Risk Assessment: (tick relevant box for each domain)

1. RISK OF HARM TO SELF	2. RISK OF HARM TO OTHERS	3. LEVEL OF SUPPORT AVAILABLE
✣ None (No thoughts or action of harm)	✣ None (No thoughts or actions of harm)	✣ No problems/ Highly Supportive (all aspects/ most aspects highly supportive/ self/ family/ professional/ effective involvement)
❑ Low (Fleeting suicidal thoughts but no plans/current low alcohol or drug use)	❑ Low (Fleeting "harm to others" thoughts but no plans/ current low alcohol or drug use)	❑ Moderately Supportive (variety of support available, able to help in times of need)
❑ Moderate (current thoughts/ distress/ past actions without intent or plans/ moderate alcohol or drug use)	❑ Moderate (current thoughts/ distress/ past actions without intent or plans/ moderate alcohol or drug use)	❑ Limited Support (few sources of help, support system has incomplete ability to participate in treatment)
❑ Significant (current thoughts/ past impulsive actions/ recent impulsivity/ some plans, but not well developed/ increased alcohol or drug use)	❑ Significant (current thoughts/ past impulsive actions/ recent impulsivity/ some plans, but not well developed/ increased alcohol or drug use)	❑ Minimal (few sources of support and not motivated)
Extreme (current thoughts with expressed intensions/ past history/ plans/ unstable mental illness/ high alcohol or drug use, intoxicated/ violent to self/ means at harm to harm self)	Extreme (current thoughts with expressed intensions/ past history/ plans/ unstable mental illness/ high alcohol or drug use, intoxicated/ violent to self/ means at harm to harm self)	❑ No support in all areas

OVERALL ASSESSMENT OF RISK: LOW

Details of Clinical Judgement relating to Risk Assessment:

Clinical experience and judgement will lead you to add other relevant factors to the risk assessment. An example, in addition to the above factors may include the presence of a medical condition or the presence of intoxication with drugs or alcohol pr forensic issues or the lack of insight. This may require a more urgent intervention because it increases risk in the short term.

Outcome Measure (please attach completed Outcome Tool copy):

K10 Score: 32

Other:

Provisional Diagnosis:

F4 Anxiety Disorders
Details if Other:

Goals:

HELP IMPROVE SYMPTOMS, REGULAR DEBRIEFING, LEARN GOOD COPING SKILLS

Relap Prevention Plan:

Plan:

Plan 1: CBT - Behavioural Interventions
If changes to medications, details:

Plan 2:

Plan 3:

Refer to 1: If refer to Other, details:
Refer to 2: If refer to Other, details:

Review Date: 29/01/2024

Patient Consent:

Patient consent obtained for preparation of this plan: Yes
Patient consent for plan to be used as a referral to other Mental Health providers: Yes

Dr Lourdes Joy Elpedes-Bolina has explained the purpose of this GP Mental Health Treatment Plan and I give permission to Dr Lourdes Joy Elpedes-Bolina to share my medical history with the clinician of the service chosen/and personnel of the chosen service where relevant.

- **I am aware that there is a Medicare fee for the preparation of this MH Treatment Plan and that there also may be fees for other Providers.**
- **The information collected is private and will be kept confidential unless agreed upon by all parties to be shared**
- **I will attend my GP for a review appointment at least 4 weeks after but before 6 months after the plan has been developed**

Patients Signature.....

Date: 26/09/2023

Dr. preparing Mental Health Treatment Plan

Dr Lourdes Joy Elpedes-Bolina
Aus Healthcare Pty Ltd T/A MediClinic Rouse Hill
18-24 ADELPHI ST

Dr's signature.....

Date: 26/09/2023