ADVANCE
MEDICAL PRACTICE
ABN: 87 251 903 304

Pitt Town Shopping Village
Shop 5/ 29 Eldon Street
Pitt Town 2756
Ph: 4572 3377
F: 4572 3399

21/01/2025

Michelle Hookham
6 Christic St
Windsor. 2756
Phone: 45774435

RE: Mrs Katrina-Lee Fraser
55 Cattai Road
Pitt Town. 2756
0449 967 275

DOB: 14/10/1981

Dear Ms,

Thank you for seeing Katrina-Lee Fraser for 6 Psychology sessions.

I have performed a GPMP today and a K10 with a score 45. Katrina is suffering with severe anxiety.

Katrina is very reluctant to start medication.

I have called NBM PHN and the PTS referral code is 14561.

I look forward to your review

Her current medications are:

Coralan 5mg Tablet	1 Tablet Daily.
Hydrozole 1%;1% Cream	Apply Twice a day for a week after rash resolved.

Allergies:

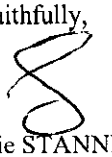
Nilstat

Past Medical History:

22/10/2021	Neck pain
22/10/2021	Neck pain
22/10/2021	Rash
27/11/2023	Pyelonephritis
04/12/2023	Gastro-oesophageal reflux disease
09/02/2024	Recurrent UTI
02/04/2024	Asthma

05/04/2024	Urinary tract infection
15/07/2024	Nausea
09/08/2024	Thrush, vaginal

Yours faithfully,



Dr Carrie STANNEY
BSc, MBBS
5260458W

BOIMHC MENTAL HEALTH 3 STEP PROCESS

PART 2 - PLAN & REVIEW

Patient Name	Mrs Katrina-Lee Fraser 4580 8321	Date of Birth	14/10/1981
GP	Dr Carrie STANNEY 0245723377	Outcome Tool Used	K10
Date of Plan	21/01/2025	Date of Review	21/04/2025
Outcome tool result at assessment	K10	Result at review	45

Problem/Diagnosis	GOAL (eg reduce symptoms, improve functioning)	PLAN Action/ Task (eg Refer for Allied Health, or pharmacological treatment, or engagement of family and other supports)	REVIEW
1.	Reduce symptoms	Anxiety	
2.			
3.			

For which Access to Allied Heath Services is the person being referred?

Diagnostic assessment Yes **Psycho-education** Yes **Interpersonal Therapy** Yes

Cognitive Behavioural Therapy (CBT): **Behavioural interventions** Yes **Cognitive interventions** Yes

Relaxation strategies Yes **Skills training** Yes

Other CBT interventions (please specify):

Other - please specify:

If referring for CBT program - Consent form signed by patient Yes / No

Relapse Prevention Plan (if appropriate)

Supportve daughter

Emergency Care

Patient Education	Yes	**Copy of MH plan given to patient**	Yes
Does the patient understand their condition?	YES		

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

Patient Signature: **Date:**

GP Signature: **Date:** 21/01/2025

Date for Mental Health Review (between 1 - 6 months):

MBS Item Numbers for Review by GP: Level C 2574 surgery and 2575 elsewhere; Level D 2577 surgery and 2578 elsewhere.
This document will be maintained in accordance with the relevant Privacy Legislation.

PSYCHOLOGICAL THERAPY SERVICES
Referral Form

phn NEPEAN BLUE MOUNTAINS An Australian Government Initiative

Wentworth Healthcare
Blue Mountains | Hawkesbury | Lithgow | Penrith

This referral is only valid with a PTS Referral Code. To obtain a referral code, GPs and other approved referrers must contact the Nepean Blue Mountains PHN dedicated referral line.

Completed referral form to be sent to the AHP with Mental Health Treatment Plan where indicated below:

Phone: 1800 223 365 Psychological Therapy Services (PTS) dedicated referral line

Date of Referral	Patient Initials	Year of Birth	Patient Gender	Patient Postcode	PTS REFERRAL CODE
21/01/2025	KLF	1981	F	2756	NBM: 14561

PTS Practitioner Details

Name: MICHELLE HOOKHAM Contact Number: 4577 4435

Fax/Email: _____

Attached, please find an assessment for a patient that I wish to refer to you under the Nepean Blue Mountains PHN Psychological Therapy Program for Focussed Psychological Strategies (FPS).

Mental Health Treatment Plan/Review and pension card required unless indicated otherwise.
Please note Aboriginal and/or Torres Strait Islanders can access any PTS stream without a pension card.

☐ Seek Out Support (SOS Suicide Prevention) **(No HCC or MHTP required)**

☑ General **(New patients only, no HCC required)**

☐ Disaster Recovery (bushfire/flood/Bondi Junction tragedy) **(No HCC or MHTP required)**

☐ Young people aged 12-25 years (HCC and MHTP required)

☐ Children aged 0-11 years (Family HCC and MHTP required)

☐ Perinatal (HCC and MHTP required)

☐ Aboriginal and/or Torres Strait Islander Peoples (MHTP required)

☐ Unpaid Carer of a person with a disability, medical condition, mental illness or frail and aged (HCC and MHTP required)

☐ Lesbian, Gay, Bisexual, Transgender, Queer, Intersex (HCC and MHTP required)

☐ Co-morbid Alcohol and Other Drugs (HCC and MHTP required)

☐ Extended (Individuals aged 25 and over with additional complex trauma) (HCC and MHTP required)

For more information on referral eligibility criteria, please visit https://www.nbmphn.com.au/pts

This patient needs to return to me for a review by: 3 MONTHS
The review with the GP is required within 12 months of the referral date

Recommendation at the conclusion of sessions (SOS referrals only):

☐ GP review not required. Patient is seeking further referral through Medicare Better Access to Psychiatrists, Psychologists, and General Practitioners. Mental Health Treatment Plan must be attached.

NB: Allied Health Professionals are entirely responsible for ensuring that appropriate MBS item(s) are billed. http://www.mbsonline.gov.au/

☐ GP review required. Patient to return to GP for review.

PATIENT INFORMATION:			
Country of Birth	☑ Australia ☐ Other (please specify) _____		
Aboriginal/Torres Strait Islander	☑ Neither ☐ Aboriginal ☐ 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 full time ☑ Employed Part time ☐ Unemployed ☐ Not in the labour force ☐ Unknown		
Source of Income	☑ Paid employment ☐ Disability Support Pension ☐ Other pension ☐ Compensation payments ☐ Other (super, investments, etc.) ☐ Nil income ☐ Unknown		
NDIS Participant	☐ Yes ☐ No ☐ Unknown	**Preferred Mode of Service Delivery**	☑ Face to Face ☐ No preference ☐ Telehealth
Last outcome measure	☑ K10 ☐ K5 ☐ SDQ Score: 45 Date Administered: _____		
Diagnosis	Severe anxiety		

KEY SUPPORTS: Patient has given consent for GP/Provider to contact support person: ☐ Yes ☐ No	
Name:	**Phone:**
Relationship to patient:	
OTHER MENTAL HEALTH PROFESSIONALS CURRENTLY INVOLVED (e.g. psychiatrist, social worker)	
Name:	**Phone:**
Name:	**Phone:**

GP Signature or Stamp:

ADVANCE MEDICAL PRACTICE
Dr Carrie Stanney
MBBS, BSc
Provider No: 5260458W
Pitt Town Shopping Village
Shop 5, 29 Eldon Street, Pitt Town 2756
Tel: 02 4572 3377 Fax: 02 4572 3399

Patient Consent: By consenting to this referral, I understand that all information in this referral, and any previous referrals (where applicable) including my personal information, will be collected for the primary purpose of delivering care; and for the ongoing monitoring, reporting, evaluation and improvement of services. I consent with the understanding that this information will only be used, disclosed and stored for its primary purpose, between my health service provider(s), the Department of Health, and the Nepean Blue Mountains Primary Health Network (NBMPHN) and affiliated partner organisation(s)*, in accordance with the *Australian Government Privacy Act, 1988.*

** Affiliated partner organisation(s) means those required to support the monitoring, reporting, evaluation and/or clinical governance for the service.*

Patient Signature **Date**

Consent for Patient under 18 years of age:

Parent/Guardian/Carer Name:

Contact number: **Email:**

Signature **Date**

K10

Date of Assessment: 21st January 2025 General Practitioner: Dr Carrie STANNEY

Patient Name: **Mrs Katrina-Lee Fraser** D.O.B: 14/10/1981

For all questions please fill in the appropriate response circle like this: ◉

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
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 will 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 is 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?	○	○	○	✓	○

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Today's date

2	1	0	1	2	0	2	5
Day		**Month**		**Year**			