

PSYCHOLOGICAL THERAPY SERVICES Referral Form



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
06.03.25	SD	1975	F	2753	NBM: 15112

PTS Practitioner Details

Name: Michelle Hookham Contact Number: 45774435

Fax/Email: health@michellehookham.com.au

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) (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:

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	<input checked="" type="checkbox"/> Australia <input type="checkbox"/> Other (please specify) _____		
Aboriginal/Torres Strait Islander	<input checked="" type="checkbox"/> Neither <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Unknown		
Marital Status	<input type="checkbox"/> Never Married <input type="checkbox"/> Married/De facto <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Unknown		
Homelessness	<input checked="" type="checkbox"/> Stable Housing <input type="checkbox"/> Short term/emergency accommodation <input type="checkbox"/> Sleeping rough		
Labour Force Status	<input checked="" type="checkbox"/> Employed full time <input type="checkbox"/> Employed Part time <input checked="" type="checkbox"/> Unemployed <input type="checkbox"/> Not in the labour force <input type="checkbox"/> Unknown		
Source of Income	<input checked="" type="checkbox"/> Paid employment <input type="checkbox"/> Disability Support Pension <input type="checkbox"/> Other pension <input type="checkbox"/> Compensation payments <input type="checkbox"/> Other (super, investments, etc.) <input type="checkbox"/> Nil income <input type="checkbox"/> Unknown		
NDIS Participant	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	Preferred Mode of Service Delivery	<input type="checkbox"/> Face to Face <input type="checkbox"/> No preference <input type="checkbox"/> Telehealth
Last outcome measure	<input checked="" type="checkbox"/> K10 <input type="checkbox"/> K5 <input type="checkbox"/> SDQ Score: _____ Date Administered: _____		
Diagnosis			
KEY SUPPORTS: Patient has given consent for GP/Provider to contact support person: <input type="checkbox"/> Yes <input type="checkbox"/> 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: Dr. S. Virk

[Handwritten Signature]



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 verbal consent Date 06.03.25

Consent for Patient under 18 years of age:

Parent/Guardian/Carer Name: _____

Contact number: _____

Email: _____

Signature _____

Date _____

GP MENTAL HEALTH CARE PLAN

ITEM: 2715

From: *Richmond Marketplace Medical Centre
Shop 46, 78 March Street, Richmond 2753
Ph: (02) 45784800 Fax: (02) 45783300*

Date: 06/03/2025

Patient Name: Miss Sarah Davy

Medicare No: 2692230115

DOB: 31/12/1975

Anxiety/ depression

Mental Status Examination:

Appearance and General Behaviour

☒ Normal ☐ Other:

Thinking (Content/Rate/Disturbances)

☒ Normal ☐ Other:

Sleep (Initial Insomnia/Early Morning Wakening)

☐ Normal ☒ Insomnia ☐ Excessive

Appetite (Disturbed Eating Patterns)

☐ Normal ☒ Reduced ☐ Overeating

Motivation/Energy

☒ Normal ☐ Not Motivated

Insight

☒ Normal ☐ Other:

Orientation (Time/Place/Person)

☒ Normal ☐ Other:

Suicidal Ideation

☐ Yes ☒ No

Mood (Depressed/Labile)

☐ Normal ☒ depressed-Anxious:

Perception (Hallucinations, etc.)

☒ Normal ☐ Other:

Cognition (Level of Consciousness/Delirium/Intelligence)

☒ Normal ☐ Other:

Attention/Concentration

☐ Normal ☒ reduced:

Memory (Short and Long Term)

☐ Normal ☒ reduced:

Anxiety Symptoms (Physical and Emotional)

☐ Normal ☒ Anxious

Speech (Volume/Rate/Content)

☒ Normal ☐ Other:

Suicidal Intent

☐ Yes ☒ No

Assessment Plan & Discussion

Anxiety/ depression

lost her job

not coping well

Goal:

- Counselling
- Learning strategies to be able to deal with all psychological issues

Provision of Psycho Education:

- Material regarding Depression; Anxiety & Bipolar

Plan for Crisis

- Life Line Penrith Regional Centre Ph: (02) 131114
- Mental Health Crisis Team Ph: 1800 011 511
- Hawkesbury Hospital Ph: (02) 4560 5555
- Surgery Phone No: (02) 4578 4800
- Surgery Facsimile No: (02) 4578 3300

Referral to Psychologist/Psychiatrist:

referral to psychologist

Review Date:

1 month

Doctor.....

Dr SUKHVINDER VIRK

096533GB

Richmond Marketplace Medical Centre

Shop 46, 78 March Street, Richmond 2753

Ph: (02) 45784800 fax: (02) 45783300

Patient.....

P. Dwyer

K10

For all questions, please fill in the appropriate response with an "X" in the space provided.

The maximum score is 50 indicating severe distress and the minimum score is 10 indicating no distress.

Questions 3 and 6 are not asked if the proceeding question was 'none of the time' in which case questions 3 and 6 would automatically receive a score of one.

In the past 4 weeks	1 None of the time	2 A little of the time	3 Some of the time	4 Most of the time	5 All the time	Score
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 could calm you down?			✓			
4. About how often did you feel hopeless?					✓	
5. About how often did you feel restless of 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?					✓	
Today's Date: 6/3/2025					Total Score	43

Patient Health Summary

Name: Miss Sarah Davy

RICHMOND MARKETPLACE MEDICAL
CENTRE

Address: 37 Town Street
Hobartville 2753

Shop 46, 78 March St
Richmond 2753
0245784800

D.O.B.: 31/12/1975

Record No.: 49622

Home Phone:

Work Phone:

Mobile Phone: 0434 585 243

Printed on 6th March 2025

Allergies/Adverse reactions:

Amoxycillin

Nurofen

Maxolon

Current Medications:

Fluoxetine 20mg Dispersible Tablet

Neo-B12 1mg/mL Injection

Oroxine 50mcg Tablet

Oroxine 75mcg Tablet

½ In the morning.

1 wkly.

1 Tablet In the morning on an empty stomach As directed.

1 Tablet In the morning on an empty stomach As directed.

Active Past History:

Endometriosis

Hyperlipidaemia

GORD

26/03/2020 Hyperthyroidism

17/04/2020 Anxiety/Depression

18/02/2021 Thyroidectomy- total

GRAVES Disease

graves disease

Inactive Past History:

Not recorded.

Immunisations:

None recorded.