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
25/02/25	ET	2003	F	2750	NBM: 14972

PTS Practitioner Details

Name: ~~Louise Walsh~~ M. Hookham Contact Number: 45019818

Fax/Email: ~~louise.walsh@optusnet.com.au~~ ~~louise.walsh@~~ hb. 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/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: 6 month
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: _____ Date Administered: _____		
Diagnosis	BPD + MDD + GAD		
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: Dokotela		**Phone:**	
Name:		**Phone:**	

GP Signature or Stamp:

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 [signature] **Date** 25/2/25

Consent for Patient under 18 years of age:

Parent/Guardian/Carer Name: _____

Contact number: _____ **Email:** _____

Signature _____ **Date** _____

GP MENTAL HEALTH TREATMENT PLAN – MINIMAL REQUIREMENTS

Notes: *This form is designed for use with the following MBS items. Users should be familiar with the most recent item definitions and requirements.*

MBS ITEM NUMBER: ☐ 2700 ☐ 2701 ☒ 2715 ☐ 2717

Major headings are ***bold;*** *prompts to consider lower case. Response fields can be expanded as required.* ***Underlined items of either type are mandatory for compliance with Medicare requirements.***

This document is not a referral letter. A referral letter must be sent to any additional providers involved in this mental health treatment plan.

CONTACT AND DEMOGRAPHIC DETAILS			
GP name	Dr Sazeedul Islam	**GP phone**	0245713399
GP practice name	North Richmond Family Medical Practice	**GP fax**	0245713538
GP address	12 Grose Vale Road, NORTH RICHMOND NSW 2754	**Provider number**	4192088A
Patient surname	Turner	**Date of birth**	10/2/2003
Patient first name(s)	Erin	**Preferred name**	Erin
Gender	Female		
Patient address	37 Greenhaven Drive, EMU HEIGHTS NSW 2750	**Patient phone** Can leave message?	☐ Yes ☐ No
Medicare No.	2908 93814 1 / 1	**Healthcare Card/Pension No.**	280624712H
Emergency contact person details		**Patient consent for healthcare team to contact emergency contacts?**	☐ Yes ☐ No

PATIENT ASSESSMENT – MENTAL HEALTH	
Reasons for presenting	BPD with GAD with MDD
Patient history Record relevant medical/ biological, mental health/ psychological, and social history	PHO BPD, Eating disorder
Results of mental state examination	Depressed, anxious
Risk assessment Note any identified risks, including risks of self-harm and harm to others	low risk
Assessment/outcome tool used and results, except where clinically inappropriate	K10
Provisional diagnosis of mental health disorder	BPD with GAD with MDD
Case formulation	CBT under GPMCP upto 6 sessions

PLAN			

Identified issues/problems	**Goals**
	Record goals made in collaboration with patient
		Treatments & interventions
		Any actions and support services to achieve patient goals
		Actions to be taken by patient
		Consider:
		• psychological and/or pharmacological options
		• face to face options
		• internet-based options
		  • myCompass
		  • THIS WAY UP
		  • MindSpot
		  • e-couch
		  • MoodGYM
		  • Mental Health Online
		  • OnTrack
			Referrals
			Or appropriate support services
			Consider:
			• referral to internet mental health programs for education and/or specific psychotherapy
			  • myCompass
			  • THIS WAY UP
			  • MindSpot
			  • e-couch
			  • MoodGYM
			  • Mental Health Online
			  • OnTrack

Intervention/relapse prevention plan If appropriate at this stage, note arrangements to intervene in case of relapse or crisis		
Psycho-education provided?	☐ Yes ☐ No	
Plan added to the patient's records?	☐ Yes ☐ No	
Completing the plan On completion of the plan, the GP may record (tick boxes below) that s/he has:		**Date plan completed**
☐ discussed the assessment with the patient ☐ discussed all aspects of the plan and the agreed date for review ☐ offered a copy of the plan to the patient and/or their carer (if agreed by patient)		

RECORD OF PATIENT CONSENT

I, **Miss Erin Turner** *(name of patient)*, agree to information about my health being recorded in my medical file and being shared between the General Practitioner and other health care providers involved in my care, as nominated above, to assist in the management of my health care. I understand that I must inform my GP if I wish to change the nominated people involved in my care.

I understand that as part of my care under this Mental Health Treatment plan, I should attend the General Practitioner for a review appointment at least 4 weeks after but within 6 months after the plan has been developed.

I consent to the release of the following information to the following carer/support and emergency contact persons:

Name	Assessment		Treatment Plan	
	Yes	No	Yes	No
	☐ with the following limitations:	☐	☐ with the following limitations:	☐
	☐ with the following limitations:	☐	☐ with the following limitations:	☐

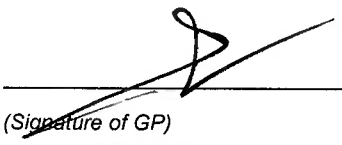
(Signature of patient)

25/02/2025

(Date)

I, **Dr Sazeedul Islam**, have discussed the plan and referral(s) with the patient

(Full name of GP)



(Signature of GP)

25/02/2025

(Date)

REVIEW	
MBS ITEM NUMBER: ☐ 2712 ☐ 2719	
Planned date for review with GP (initial review 4 weeks to 6 months after completion of plan)	
Actual date of review with GP	
Assessment/outcome tool results on review, except where clinically inappropriate	
Comments Review of patient's progress against goals; checking, re-enforcing and expanding education; modification of treatment plan if required	
Plan for crisis intervention and/or for relapse prevention, if appropriate and if not previously provided	