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
11/5/25	KF	1981	F	2756	NBM: ~~WAGOT~~ 15798

PTS Practitioner Details

Name: Jessica Yang Contact Number: 45723377

Fax/Email: ~~jessica~~ pittown@theamp.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: 6 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: 21/1/25		
Diagnosis	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:

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** 1/5/25

Consent for Patient under 18 years of age:

Parent/Guardian/Carer Name: _____

Contact number: _____ **Email:** _____

Signature _____ **Date** _____