

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
22/05/2025	JMcG	1965	F	2756	NBM: 10778

PTS Practitioner Details

Name: Michelle Hookham Contact Number: 0423 162 001
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/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: 22/05/2026

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 checked="" 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 type="checkbox"/> Employed full time <input type="checkbox"/> Employed Part time <input type="checkbox"/> Unemployed <input checked="" type="checkbox"/> Not in the labour force <input type="checkbox"/> Unknown		
Source of Income	<input type="checkbox"/> Paid employment <input type="checkbox"/> Disability Support Pension <input checked="" 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 checked="" 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: <u>30</u> Date Administered: <u>22/5/25</u>		
Diagnosis	<u>POST TRAUMATIC STRESS DISORDER</u>		

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:



Dr. Therese Roberts
Provider No. 049686DH
Kellyville Village Medical Centre
Shop 10 (inside next to Coles)
90 Wrights Rd, Kellyville NSW 2155
Tel: (02) 8814 1555 Fax: 8814 1786

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 22.5.25

Consent for Patient under 18 years of age:

Parent/Guardian/Carer Name: _____

Contact number: _____

Email: _____

Signature _____

Date _____

Patients name	Mrs Julie McGrath	Date of Birth	13/10/1965
Address	1/620 A George Street South Windsor 2756	Phone	(02) -
Carer details and/or emergency contact(s)		Other care plan	YES <input type="checkbox"/>
GP Name / Practice	Kellyville Village Medical Centre	Eg GPMP / TCA	NO <input type="checkbox"/>

AHP or nurse currently involved in patient care	Medical Records No.
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PRESENTING ISSUE(S) depressed mood
What are the patient's anxiety
current mental health reliving past relationship trauma
issues

PATIENT HISTORY depression

Record relevant biological
 psychological and social
 history of mental disorders
 and any relevant
 substance abuse or
 physical health problems

MEDICATIONS

(attach information if required)	Atozet 10mg;80mg Tablet	1 Tablet In the evening.
	Cartia 100mg Tablet	1 Tablet Daily.
	Jardimet 12.5/1000 12.5mg; 1000mg Tablets	1 Tablet Twice a day.
	Pantoprazole 40mg Tablet	1 Tablet In the evening.
	Perindopril 4mg Tablet	1 Tablet Daily.
	Sotalol 80mg Tablet	½ Twice a day.
	venlafaxine 37.5mg	daily

ALLERGIES Nil known.

**ANY OTHER RELEVANT
INFORMATION** separated from husband since 2005
 myocardial infarction, pacemaker 2018
 Type 2 Diabetes

**RESULTS OF MENTAL
STATE EXAMINATION** Pleasant woman of stated age who has attended requesting renewal of her Mental Health
Record after patients has Care Plan so that she can continue to engage in regular therapy with her psychologist. Julie
been examined has a complex personal history and has needed to deal with numerous traumatic and
 emotinally challenging events throughout her life. She has battled with persistent depressive
 symptoms and struggles with anxiety. She has found regular sessions with her psychologist
 highly beneficial.

**RISKS AND
CO-MORBIDITIES** nil
**Note any associated risks
and co-morbidities
including suicidal
tendencies and risk to
others**

OUTCOME TOOL USED RESULTS:
k10 30
DIAGNOSIS Complex Trauma Reaction; depression

NEEDS / MAIN ISSUES

to process and develop strategies to help her deal with
memories of previous and significant relationship trauma
to improve wellbeing

mental health goals agreed to by the patient
and any actions the patient will need to take

INTERVENTIONS

Interventions, actions and support services to achieve
goals

cbt
ipt
mindfulness
supportive therapy

RELAPSE PREVENTION

1, note the arrangements for crisis intervention
relapse prevention

LS
referrals to be provided by GP, as required, in up
to six sessions. The need for the second
sessions to be reviewed after the initial six

**APPROPRIATE PSYCHO-EDUCATION PROVIDED
ADDED TO THE PATIENT'S RECORDS
(OR PARTS) OF THE PLAN OFFERED TO
PROVIDERS**

Yes
Yes
Yes

COMPLETING THE PLAN

Completion of the plan, the GP is to record that
has discussed with the

ASSESSMENT

Subjects of the plan and the agreed date for review;

and a copy of the plan to the patient and/or their
if agreed by patient)

22/05/2025

PLAN COMPLETED:

DATE (initial review 4 weeks to 6 months after
completion of plan):

REVIEW COMMENTS (Progress on actions and tasks)

ADDITIONAL TOOL RESULTS ON REVIEW