PHN Referral Point

Psychological Therapies Service Referral Form

Please send this form to the Referral Point Team via:

Print, sign and fax: 1300 260 814

PHN OFFICE USE ONLY
Client ID:
Referral ID:
Date Received:

REFERRAL DETAILS: Please place an X in appropriate boxes.

MUST BE COMPLETED: Minimum Data Set Required for Reporting to National Funding Source											
Referral Information											
Date of Referral:					**Referral Type:**		**Adult**				
Referring GP:							**Children (0-12 yrs)**				
Address							**Suicide Prevention**				
					Prior Mental Health Care?		Yes		No		
Telephone:		Fax:			Existing Client ID: (If known)						
Patient Information											
First Name:		Surname:			Gender						
Address:					Date of Birth:						
					Home Phone:						
Lives Alone:		Yes		No	Mobile						
Parent/Guardian Name: (if under 16 yrs)											
Country of Birth											
Language:		English Only	Other:								
Speaks English:		Very well		Well		Not well		Not at all		Interpreter required	
Patient identifies as:		Aboriginal		Torres Strait Islander				LGBTQI		Low Income Earner	
Education Level:		Tertiary		Year 12		Year 11		Years 7-10		Primary or below	

ICD-10 Primary care diagnostic categories – *please select those that apply*

	F1 Alcohol & drug use		F3 Depression		F5 Unexplained somatic	Other:
	F2 Psychotic disorders		F4 Anxiety Disorders		No formal diagnosis	

Referred for which strategies – *please select those that apply*

	CBT		Psycho-education		Interpersonal Therapy		Narrative Therapy
	Skills Training		Relaxation Strategies		Other:		

Receiving Psychotropic Medications – *please select those that apply*

	None		Benzodiazepines & anxiolytics		Mood stabilisers
	Antidepressants		Phenothiazines & tranquillisers		Other:

PATIENT CONSENT

The patient consents to transfer of personal information between GP, Western Victoria PHN and a clinical service to which they may be referred.
The patient understands the treatment plan and agrees to the referral to Western Victoria PHN.
The patient understands that their consent may be withdrawn at any time.
Please Note: All personal information will be handled according to Commonwealth and State privacy laws.

PREFERRED PROVIDER if applicable

Preferred Provider:

GP signature:_____

Patient signature:_____

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Please complete Mental Health Treatment Plan (MHTP) below or attach a MHTP from another source. A MHTP is required for all referrals except:

- Suicide prevention and
- If referrer is an Aboriginal and Torres Strait Island Health Practitioner

PRESENTING ISSUES AND BACKGROUND

1. SUMMARY OF PRESENTING PROBLEM/S

2. INITIAL SCREENING RESULT (K10): /50 **DATE ADMINISTERED:**

3. RELEVANT MEDICAL ISSUES AND CURRENT TREATMENTS

4. DEVELOPMENTAL HISTORY (Consider childhood, schooling, work, relationships, genogram, trauma)

5. CURRENT SUPPORTIVE NETWORKS (Consider family, friends, colleagues, church, interest groups)

6. DETAILS OF MENTAL HEALTH HISTORY AND TREATMENT

7. OTHER SERVICES INVOLVED: Please detail and also include contact person if possible.

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8. MENTAL STATUS ASSESSMENT

Appearance/general behaviour	
Mood (depressed/labile)	
Thinking	
Insight	
Perception (Hallucinations etc)	
Cognition	
Attention/concentration	
Memory	
Sleep	
Appetite	
Anxiety symptoms	
Speech	

9. SUBSTANCE USE

	Nil	Light	Moderate	Heavy
Tobacco				
Alcohol				
Other - please specify				

10. RISK ASSESSMENT

	Nil	Low	Mod	High	Rationale (consider history, ideation, intent, plan, protective factors)
Suicidal risk					
Risk of non-suicidal self harm					
From others *eg domestic violence*					
To others					

11. SUMMARY

TREATMENT PLAN

Patient Problem/Diagnosis	**Goal** (eg reduce symptoms, improve functioning)	**Action/Task** (eg psychological or pharmacological treatment, referral, engage support of family or other agencies)
Issue 1		
Issue 2		
Issue 3		