PeninsulaGP Network

Access to Allied Psychological Services (ATAPS)

To be completed by the GP and returned to PGPN by fax: 9708 8157

Referral Details: (please print)

Referral Date: / /2012 *(Note: This is the date of the consultation)*

Is this a re-referral? ☐ yes ☐ no

TIER 1 ☐ Standard ATAPS

TIER 2 ☐ Perinatal Depression ☐ Suicide / Self Harm

Referring GP: ______________________ Practice Postcode: __________

If Locum GP, Please state the Practice Name rather than GP Name

Allied Health Professional: ______________________ Phone: (03) __________

Patient Details:

Patient Name (please print):

Date of Birth: / /

Contact Phone No.:

Residential postcode:

Gender: ☐ male ☐ female

Is the patient: ☐ Adult ☐ Child ☐ Youth

ATSI Status:

☐ Aboriginal ☐ Torres Strait Islander

☐Unknown ☐ No

Main language spoken at home? *(Only answer this question if patient has identified that they speak a language other than English)*

____

How well does the patient speak English?

☐ Very well ☐ Not well

☐ Well ☐ Not at all ☐ Unknown

Patient Details for Referral:

Does the patient live on his / her own?

☐ yes ☐ no ☐ unknown

What is the highest level of education completed by the patient?

☐ Primary or below

☐ Secondary (year 10

(completed yrs 7,8 or 9 included in this response)

☐ Secondary (year 11 / equivalent)

☐ Secondary (year 12 / equivalent)

☐ Tertiary

Is the patient a low income earner?

☐ yes ☐ no ☐ unknown

Healthcare card number: ______________

Has the patient ever received specialist mental health care before?

☐ yes ☐ no ☐ unknown

☐ **Mental Health Treatment Plan has been claimed for this patient (**MBS item 2700/2701/2715/2717)

Clinical Details:

ICD 10 Diagnostic Categories

F1 Alcohol and drug use disorders ☐

F2 Psychotic disorders ☐

F3 Depression ☐

Perinatal Depression: Ante ☐ Post ☐

F4 Anxiety disorders ☐

F5 Unexplained somatic disorders ☐

Unknown ☐

Other: ______________________ ☐

Perinatal Depression Details

At Referral, number of weeks pregnant: ______________

Due Birth Date: ______________

At Referral, number of weeks post-natal: ______________

Actual Birth Date: ______________

Which focused psychological strategy (FPS) is the patient being referred for?

Diagnostic Assessment ☐

Psycho-education ☐

Cognitive Intervention (CBT) ☐

Behavioral Intervention (CBT) ☐

Relaxation Strategies (CBT) ☐

Skills Training (CBT) ☐

Other CBT Interventions______________ ☐

Interpersonal Therapy ☐

Narrative Therapy ☐

Family Therapy (Perinatal Depression) ☐

Other Please specify: ______________

Is the patient receiving psychotropic medication at referral?

Benzodiazepines / anxiolytics ☐

Antidepressants (Incl. SSRIs, SNRIs and TCAs) ☐

Antipsychotics ☐

(Resperidone, olanzapine, clozapine, haloperidol, chlorpromazine)

Mood Stabilisers ☐

(Incl. lithium carbonate, sodium valproate, carbamazepine)

Psychological Measure completed:

Outcome tool	Score

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The patient must read and sign the consent form. The GP must also sign the consent form. This form including referral notification and consent must be returned to Mental Health Program Administrator at PGPN.
Once approved, this referral will be forwarded to an allied health provider chosen by you or PGPN. Please direct any enquiries to PGPN on Ph: 9708 8019 or email j.stubbs@pgpn.org.au

PATIENT PRIVACY and CONSENT FORM

Your GP has referred you to an Allied Health Professional for Focused Psychological Strategies. Participation in this program will require your GP to provide some information about you to the allied health professional about your treatment and vice versa.

For the purpose of evaluation and reporting, some of your personal information including name and date of birth, as well as information about the type of mental health concern you are experiencing will be recorded. Some of this information will be provided to the Australian Government Department of Health and Ageing, who are funding this program. Please note that identifying information such as your name and date of birth will not be passed on.

Peninsula General Practice Network is committed to providing you with the highest level of confidentiality and customer service; this includes protecting your privacy.

Peninsula General Practice Network is bound by the Commonwealth Privacy Act 1988, which outlines the principles concerning the protection of your personal information.

RECORD OF PATIENT CONSENT:
Please ☑ to indicate who is consenting to collection, use and disclosure of personal health information.
☐ Patient is consenting – adult patient
☐ Patient is consenting – child / adolescent (parent / guardian consent has not been sought)
☐ Parent / Guardian consent – child / adolescent patient

I agree to information about my mental health and well being to be collected, used and disclosed to the allied health provider I am referred to, to assist in the management of my health care.

I am also aware that information (that will not identify me) is being collected and used to assist in the management of the ATAPS program, and I agree to this de-identified data being collected and shared.

______________________	______________________	___/___/___
Patient Name	Patient Signature	Date
______________________	______________________	___/___/___
Parent / Guardian Name	Parent / Guardian Signature	Date

PLEASE RETURN THIS FORM WITH ALL SECTIONS COMPLETED TO ENSURE THE REFERRAL OCCURS AS SOON AS POSSIBLE

I hereby notify Peninsula General Practice Network that I have referred this patient to an allied health professional for services as part of the Better Outcomes in Mental Health Care Initiative and have completed an assessment as the first step in the Mental Health Care Plan process.

To the best of my knowledge this patient is a low income earner, or qualifies under Tier 2-Perinatal Depression, Suicide/Self harm.

GP Signature: ______________________