Referring GP:

Psyc Referral to:

Dr Stephen Wolfson
Provider No. 5340201J
307/39 East Esplanade,
Manly NSW 2095 Australia
steve@neurocogsystem.com
Phone 02 82249670
Fax 02 8224 9674

_____

Date

Dear Dr. Stephen Wolfson,

Please see_____*(Full Name of patient)* for psychological assessment and therapy under a Mental Health Care Plan (MHCP).
I approve 6 initial sessions with a Psychologist/Clinical Psychologist under Better Access.
Please see patient's information and MHCP below.

I look forward to receiving your written progress report regarding this patient upon completion of the 6 sessions for approval of additional sessions if needed.

Yours sincerely,

Referring GP signature

Adult Referral/Mental Health Treatment Plan

MBS item number	2700	**Referral Date**	

PATIENT INFORMATION

Name	
Date of Birth	
Gender	
Medicare/Ref Number	
Healthcare Card/ Pension No.	
Contact Email	
Mobile Phone Number	
Home Address	
Other care plan	N/A
AHP or nurse currently involved in patient care	
Medical Records No.	
Children age 0-18?	No

EMERGENCY CONTACT

Name	
Relationship	
Phone Number	
Email	

MENTAL HEALTH ASSESSMENT

(select from drop downs and use fill in's as needed)

Appearance and Behaviour	Typical
Affect	Typical
Sleep	Normal
Appetite	Typical
Motivation/Energy	Typical
Judgement/Insight	Typical
Speech	Typical
Mood	Typical
Thinking	Typical
Perception	Typical
Andehonia	None
Attention/Concentration	Typical
Memory	Typical
Orientation	Typical

MENTAL STATE EXAMINATION

(select from drop downs)

A rating of 4 should be referred to the Mental Health Access Line on 1800 011 511 or 000

1. Symptom severity and distress *(Consider the severity, duration, complexity, and distress resulting from the person's symptoms)*

0 = No descriptors above apply

2. Risk of harm *(Consider the level of risk as it relates to the person's potential for harm to self or others including domestic violence, aggression and forensic***)**

3=Suicidal ideation/intent/past attempts; no plan/strong reluctance to carry out/protective factors/commitment to safety plan, involvement family/others/services

3. Functioning *(Consider the person's ability to function in their daily duties and roles)*

0 = No descriptors apply

4. Co-existing Conditions *(Are there co-existing conditions impacting on mental health or ability to participate in treatment?)*

0 = No co-existing conditions are present

4a. Impact of co-existing conditions

0 = No co-existing conditions are present

5. Treatment and recovery history *(Consider the person's previous treatment history, current service use and response to past or current treatment)*

0 = No prior treatment history

6. Social and environmental stressors *(Consider how the person's environment is contributing to their mental health condition; items - economic, occupational, relational, familial, legal, environmental)*

0 = No items

7. Family and other supports *(Consider the informal supports that are available and capable of contributing to recovery)*

0 = Complete understanding of condition; active/motivated management; accesses supports

7a. Please list the most useful supports available to the person

8. Engagement and motivation *(Consider if the person understands their mental health condition, capacity to manage their condition and their willingness/motivation to participate in treatment)*

0 = Complete understanding of condition; active/motivated management; accesses supports

Case Formulation (factors: predisposing, precipitating, perpetuating, protective)

CLIENT HEALTH AND PLAN

(select from drop downs and use fill in's as needed))

Provisional diagnosis DSM/ICD 10/11 of mental health disorder

Deferred

Deferred

General Diagnosis

None

Client Medication

Outcome Tool Used

Tool	Date	Score
None		

Clients Needs/Issues

None

None

None

Goals

None

None

Interventions/ Relapse Prevention

Exploration of Relationship Patterns

Referrals

None

Crisis/Relapse

None

Psychoeducation provided? ☐

Plan added to the client's records? ☐

Copy of the plan offered to other provider/client? ☐

Assessment, referral and treatment options discussed? ☐

Discussed Plan and Review Date? ☐

Date Plan complete

Notes

RECORD OF PATIENT CONSENT

I, _____*(name of patient),* agree to information about my health being recorded in my medial file and shared between health care providers included in this form involved in management of my healthcare. I understand I must inform my GP if I wish to change any provider listed in this form. I understand as part of my care under this Treatment Plan, I should attend my GP for review at least 4 weeks after but within 6 months after this plan was created. I consent to the release of the following information to care support and emergency contacts:

Name	Assessment		Treatment Plan	
	Yes	No	Yes	No
	☐ With the following limitation:	☐	☐ With the following limitation:	☐
	☐ With the following limitation:	☐	☐ With the following limitation:	☐
	☐ With the following limitation:	☐	☐ With the following limitation:	☐

Signature of patient *Date*

I, _____have discussed the plan and referral(s) with the patient.
Full name of GP

Signature of GP *Date*