Addressee: Date:

**RE:**

Thank you for seeing , who is currently a patient of mine. \_\_\_\_\_\_\_\_\_\_\_\_\_\_is currently experiencing: [<<Current Presentation>>](#CUSTOM)

The reason for this referral is: [<<Reason for referral>>](#CUSTOM). The following is the patient's recent GPMHTP for consideration.

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| **PATIENT DETAILS:** |
| **Patient Name**  |  |
| **Address:** |  |
| **Phone Number** | **Landline Mobile** |
| **Assessment Date**  |  |
| **DOB**  |  |
| **Gender**  | Male / Female / Does not identify |
| **Aboriginal &/or Torres Strait Islander** |  |
| **Ethnicty & language**  | EthnicityLanguage spoken at homeEnglish proficiencyInterpreter requirements: |
| **Medicare card Number**  |  |
| **Health care card number** |  |

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| **PATIENT HISTORY - GENERAL** |
| **Clinical History** |  |
| **Medications** |  |
| **Allergies** |  |
| **Significant Family History** |  |
| **Significant cultural factors** |  |

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| **SOCIAL HISTORY** |
| **Education level:**  |  |
| **Living status:**  |  |
| **Support person/s:** |  |
| **Activities, Hobbies & Peer Relationships:** |  |
| **Drug / Alcohol / Steroid Use:** |  |

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| **MENTAL STATUS EXAMINATION** |
| **Appearance and general behaviour** | [<<Appearance and general behaviour>>](#CUSTOM) | **Mood** | [<<Mood (Depressed / Labile )>>](#CUSTOM) |
| **Thinking**  |  [<<Thinking (Content / Rate / Disturbances)>>](#CUSTOM) | **Affect**  | [<<Affect (Flat / Blunted)>>](#CUSTOM) |
| **Perception** | [<<Perception (Hallucinations etc)>>](#CUSTOM) | **Sleep** | [<<Sleep (Initial Insomnia / Early Morning Wakening)>>](#CUSTOM) |
| **Cognition** | [<<Cognition (Level of consciousness/ delirium / intelli>>](#CUSTOM) | **Appetite**  | [<<Appetite (Disturbed Eating Patterns)>>](#CUSTOM) |
| **Attention / Concentration** | [<<Attention and concentration>>](#CUSTOM) | **Motivation & energy** | [<<Motivation and energy>>](#CUSTOM) |
| **Memory** | [<<Memory (Short & Long term)>>](#CUSTOM) | **Judgment** |  [<<Judgment (Ability to make rational decisions)>>](#CUSTOM) |
| **Insight** | [<< Insight>>](#CUSTOM) | **Anxiety symptoms** | [<<Anxiety Symptoms (Physical & Emotional)>>](#CUSTOM) |
| **Orientation**  | [<<Orientation (Time / place / person)>>](#CUSTOM) | **Speech**  |  [<<Speech (Volume / Rate / Content)>>](#CUSTOM) |

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| **RISK ASSESSMENT** |
| **Suicidal ideation** |  |
| **Suicidal intent** |  |
| **Current plan** |  |
| **Risk to Others** |  |
| **Other risk issues identified:** |  |
| **Overall risk rating:** | **Low / Medium / High** |

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| **FORMULATION** |
| **Formulation summary** |  |
| **Primary Diagnosis** |  |
| **Secondary Diagnosis** |  |
| **K10 + SCORE** |  |

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| **CARE PLAN** |
| **PROBLEM / ISSUE** | **GOAL** | **ACTION** |
| [<<Problem / issue 1>>](#CUSTOM) | [<<Goal 1>>](#CUSTOM) | [<<Action 1>>](#CUSTOM) |
| [<<Problem / issue 2>>](#CUSTOM) | [<<Goal 2>>](#CUSTOM) | [<<Action 2>>](#CUSTOM) |
| [<<Problem / issue 3>>](#CUSTOM) | [<<Goal 3>>](#CUSTOM) | [<<Action 3>>](#CUSTOM) |

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| **CRISIS PLAN / EMERGENCY PLAN** |
| Specific crisis management instructions:  |  |
| GP practice number: |  |
| GP after hours call line: | 1800 022 222 |

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| **GENERAL SUPPORT SERVICES** |
| **Websites** | **Smart phone Apps** | **Phone support** |
| **The Brave Program (Anxiety)**<https://brave4you.psy.uq.edu.au/> Reach Out <https://au.reachout.com/> Bite Back <https://www.biteback.org.au/> eHeadspace<https://www.eheadspace.org.au/> Youth Beyond Bluehttps://www.youthbeyondblue.com/  | Smiling MindMind the BumpWorry TimeThe Desk | Emergency: 000 Lifeline: 13 11 14Kids helpline: 1800 55 1800Youthblue: 1300 224 636Women’s support line: 1300 134 130Safesteps (family violence) 1800 015 188Domestic violence line: 1800 737 732 BraveHearts 24hrs: 1800 272 831Suicide line 1300 651 251Suicide call back line 1300 659 467 |

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| **REFERRAL INFORMATION** |
| **Date of Mental Health Plan Review:** |  [<<Date of Mental Health Plan Review: >>](#CUSTOM) |
| **Patient education provided:** | [<<Patient information given>>](#CUSTOM) |
| **Copy of MH plan provided to patient:** | [<<Copy of MH plan given to patient:>>](#CUSTOM) |
| **Mental Health Program Eligiblity** | [Better](#CUSTOM) Access – Medicare (employed)PTS – Low intensityPTS – Moderate IntensityPMHCCC – Episodic severe intensityPMHCCC – Chronic enduring intensity |
| **Preferred patient contact method and time:** | [<<Preferred patient contact method and time>>](#CUSTOM) |

**NB: If referring to Murray PHN Mental Health Care Program - PTS or MHCCC,**

**Please call 1300 514 811 whilst the patient is still in the consultation so we can**

**streamline the referral quickly. Then please fax this GPMHTP & referral form to: 03 9376 0317**

**PATIENT CONSENT:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ consent for this Care Plan to proceed and I agree to information about my mental health being shared between my GP and the mental health worker to whom I am referred, to assist in the management of my health care.

To enable this referral to proceed, I also agree to information to be provided to the mental health intake line.

**Signature (patient): Date: 1/03/2018**

**Patient Name**

I, Dr \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have discussed the proposed referral(s) with the patient and am satisfied that the patient understands the proposed uses and disclosures and has provided their informed consent to these.

**GP Signature:** **Date: 1/03/2018**

**Dr A Practitioner**

This document will be maintained in accordance with the relevant Privacy Legislation.