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| CHILD MENTAL HEALTH TREATMENT PLAN & REFERRAL FORM |

<<Addressee:Full Details>> <<Miscellaneous:Date (long)>>

Dear: <<Addressee:Name>>

**RE: <<Patient Demographics:Full Name>> <<Patient Demographics (long)>>**

Thank you for agreeing to see <<Patient Demographics:Full Name>> whom has is currently a patient of mine. <<Patient Demographics:First Name>> parent / carer, has reported: [<<Presenting issues / problems>>](#CUSTOM%22%20%5Cl%20%22%7CC%7C0%7C%7C0%7C).

The reason for this referral is: [<<Reason for referral:>>](#CUSTOM%22%20%5Cl%20%22%7CC%7C0%7C%7C0%7C)

The following assessment has been completed with an initial treatment plan developed:

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| GP CONTACT AND DETAILS | | | |
| **GP name:** |  | **GP phone:** |  |
| **GP practice:** |  | **GP fax:** |  |
| **GP address:** |  | **Provider no:** |  |
| PATIENT DETAILS | | | |
| **First name** |  | **Given Names:** |  |
| **Surname:** |  | **DOB:** |  |
| **Gender:** |  | **School status:** | School year level:  School name: |
| **Patient phone:** |  |
| **Parent / Gardian name:** | First name:  Surname: | **Relationship:** | Relationship:  Emergency Contact? |
| **Landline no:** |  | **Mobile:** |  |
| **Address:** |  | **Postcode:** |  |
| **Cultural status:** | Aboriginal and Torres Strait Islander Status: |  | |
| Nationality: |  | |
| Language spoken at home: |  | |
| Interpreter required: |  | |
| Other cultural issues: |  | |
| **Parental social status:** | Employment: |  | |
| Marital status: |  | |
| Custodial arrangements: |  | |
| Health Cover / Medicare | Pension number:  Medicare number:  Health Insurance: | |
| Parent level of literacy: |  | |
| **Family status:** | Other siblings? |  | |
| Living arrangements: |  | |
| Significant connections / relatives |  | |

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| PHYSICAL HEALTH: | | | |
| **Allergies:** |  | **Medications:** |  |
| **Physical health:** |  |
| **Physical examinations & investigations:** | |  | |

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| FAMILY INFORMATION | |
| **Family mental health** |  |
| **Family substance use** |  |
| **Family domestic violence / forensic history** |  |
| **Family breakdown** |  |
| **Family physical health** |  |
| **Family economic factors**  **(housing / employment / financial)** |  |

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| CHILD HISTORY: | |
| **Current issues / symptoms: (Incl.implication on daily activities)** |  |
| **Salient developmental history:**  **(speech, milestones, attention, behaviour)** |  |
| **Mental health history:**  **(Incl.Recent psychological testing)** |  |
| **History of trauma:** |  |
| **Salient social history:** |  |
| **Salient substance use issues:** |  |

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| CHILD ASSESSMENT: | | | | | |
| SDQ score (Strengths & Difficulties Questionnaire) | | |  | Date: |  |
| **Mental state** | Mood:  Anxiety:  Anger/ Irritability:  Somatic complaints:  Perceptual disturbances:  Restlessness/ agitation:  Other (describe): | | | | |
| **Relational / social:** | Peer concerns (e.g. bullying):  Sibling relationships:  Parent – child attachment:  Isolation / withdrawal:  Other (describe): | | | | |
| **School** | Socialisation:  School refusal / attendance:  School performance: | | | | |
| **Risk issues** | Substance use:  Self-harm:  Suicidal ideation:  Suicidal intent:  Past suicide attempts:  Parental / family history of suicide:  Running away:  Other risk issues: | | | | |
| ***Note:*** *Children who are at* ***acute*** *or* ***immediate risk*** *of suicide or self-harm or who have a severe and persistent mental illness should be referred to the Emergency Department / or local Public CAMHs Service. If there is risk of significant harm to the child, refer to the Child Protection.* | | | | | |
| **Provisional diagnosis or formulation:** | |  | | | |

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| CHILD CARE PLAN: | | |
| **Identified issue** | **Goal** | **Plan** |
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| **Specific Crisis Support Plan** | Specific instructions:  GP phone no: | |

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| General supports and contact numbers: | | |
| **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/>  Autism games (for parents to use with children)  <http://www.autismgames.com.au/> | Smiling Mind  Mind the Bump  Worry Time  The Desk | Emergency: 000  Lifeline: 13 11 14  Kids helpline: 1800 55 1800  Parent line: 13 22 89  Women’s support line: 1300 134 130  Safesteps (family violence) 1800 015 188  Child protection helpline: 13 13 78  Domestic violence line: 1800 737 732  GP line after hours: 1800 022 222  Maternal and child helpline: 13 22 29  BraveHearts 24hrs: 1800 272 831 |

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| REFERRAL INFORMATION | | | |
| Psycho-education provided? |  | | |
| Copy of plan provided? |  | MHTP review date: |  |
| Referral program: |  | Referral ID No: |  |

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| CONSENT | | | |
| I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agree /consent to this management plan and referral.  I also give my consent for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ medical information to be provided to the referred provider outlined in this treatment plan.  I also consent for this referral to be provided to the intake/referral line to enable referral to be facilitated.  Please indicate if verbal consent given in lieu of signed consent: | | | |
| Parent signature | Date: | GP signature | Date |
| Parent name: | | GP details | |

REMINDER: Referrals to Murray PHN children’s mental health program:

Please phone 1300 514 811 whilst the patient is in the consultation

Please fax this treatment plan to: 03 9376 0317 upon acceptance of referral.