

***The Heritage Medical and Dental Clinic***  
***58 March Street***  
***Richmond NSW 2753***

***Ph: (02) 4578 2445***

***Fax: (02) 4588 6977***

**Dr Kate Pham**  
**Mbbs(Sydney), Fracgp**  
**210173FX**

29/04/2024

Dear Ms Michelle Hookham,

**Re: Miss Silvana Virzi**  
141 Bull Ridge Road  
East Kurrajong  
12/09/2006

Thank you for seeing Miss Silvana Virzi, age 17 yrs, for GAD.

**Past History:**

08/04/2024      Generalised Anxiety Disorder

**Allergies:**

Ceclor                      rash

**Current Medications:**

Fluoxetine 20mg Capsule  
Lorazepam 1mg Tablet

1 Capsule Daily As directed.  
half Twice a day.

Yours sincerely,



Dr Kate Pham

## 1. Patient Assessment

Miss Silvana Virzi  
141 Bull Ridge Road  
East Kurrajong 2756

Outcome Tool  
K10

Result  
24

12/09/2006

Female

18/04/2024

Name: Dr Barbara Siddiqi  
Practice: Heritage Medical Clinic  
Provider No: 212625FH

Mixed anxiety and depression  
GAD

No long term medications.

19/06/2019 Viral illness  
16/05/2022 Viral illness  
08/04/2024 Generalised Anxiety Disorder

Has the person ever received specialist mental health care? Yes

### Other Relevant Information:

Language spoken at home: English

How well does the person speak English: Very well

Mother: Anxiety

Father: Not recorded

Other details:  
grandmom smoke  
grandad niddm

Occupation: Pastry Chef Apprentice

Marital status: Single

Sexual Orientation: Heterosexual

Smoking:  
Non smoker

Does the person live alone: Yes

Highest education level completed: Secondary to Year 11

### Other Relevant Information:

Alcohol: occasional

Smoking: Nil  
N/A

Cecilor rash

Prone to lifelong anxiety

wnl

<b>Appearance and General Behaviour</b> Tidy, good eye contact	<b>Mood</b> (Depressed/Labile) congruent
<b>Thinking</b> (Content/Rate/Disturbances) <input checked="" type="checkbox"/> Normal/Clear <input type="checkbox"/> Other:	<b>Affect</b> (Flat/blunted) normal
<b>Perception</b> (Hallucinations etc.) <input checked="" type="checkbox"/> Normal <input type="checkbox"/>	<b>Sleep</b> (Initial Insomnia/Early Morning Wakening) <input checked="" type="checkbox"/> Normal <input type="checkbox"/> disturbed
<b>Cognition</b> (Level of Consciousness/Delirium/Intelligence) <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Other:	<b>Appetite</b> (Disturbed Eating Patterns) <input type="checkbox"/> Normal <input type="checkbox"/> Other:
<b>Attention/Concentration</b> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Other:	<b>Motivation/Energy</b> <input type="checkbox"/> Normal <input checked="" type="checkbox"/> Other: variable
<b>Memory</b> (Short and Long Term) <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Other:	<b>Judgement</b> (Ability to make rational decisions) <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Other:
<b>Insight</b> <input checked="" type="checkbox"/> Present <input type="checkbox"/> Other:	<b>Anxiety Symptoms</b> (Physical & Emotional) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Orientation</b> (Time/Place/Person) <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Other:	<b>Speech</b> (Volume/Rate/Content) <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Fast/slow

<b>Suicidal Ideation</b>	nil	<b>Suicidal Intent</b>	nil
<b>Current Plan</b>	nil	<b>Risk to Others</b>	nil

mum 0424 173 351

Family and friends buffers

michelle hookham 6 christie st windsor 45774435  
health@michellehookham.com.au  
nepean mental health

Patient Education Given

## 2. Mental Health Care Plan

Patient Name	Miss Silvana Virzi 141 Bull Ridge Road East Kurrajong 2756				
DOB	12/09/2006	Gender	Female	Date	18/04/2024

Presenting problem(s)	What do you want to achieve?	Who can help you achieve this? (Family and other supports)
Mixed anxiety and depression	Improve mood, reduce anxiety	m hookham, dr pham, dr siddiqi
GAD	Improve mood, reduce anxiety	as above

Emergency Contact Details	Emergency contact details
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Patient Education given:	No	GP/Health Support Telephone:
Copy of this Plan given to patient:	Yes	mum 0424 173 351

Review Date	after initial 4-6 visits
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<b>I, Miss Silvana Virzi</b> Consent to this Care Plan to proceed and I agree to information about my mental health being recorded in my medical file and being shared between the GP and the counsellor(s) to whom I am referred, to assist in the management of my health care.		
x	18/04/2024	
Signature (patient):	Date:	
<b>I, Dr Barbara Siddiqi</b> 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	Dr Barbara Siddiqi	18/04/2024
	GP Name	Date

Name:	Dr Barbara Siddiqi
Practice:	Heritage Medical Clinic
Provider No:	212625FH