

Myhealth North Richmond

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www.myhealth.net.au/north-richmond/

26/07/2024

Michelle Hookham
Old Hawkesbury Hospital
6 Christie St
Windsor. 2756
Phone: 02 4577 4435
health@michellewilliams.com.au

re. **Miss Leila Henshaw**
17/03/2006
2190 Bells Line Of Rd
Bilpin. 2758
0472567023

Dear Michelle,
re: MH CP x6 session
NBM approval 12419

Thank you for seeing Leila Henshaw for an opinion and management. She is an 18 yr old with ADD and anxiety and poss of PTSD. Kindly send me correspondence of her progress.
Her current medications are:

Vyvanse
Dexamfetamine

Allergies:
Nil known.

Past Medical History:

2018	Anxiety ADD
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Yours faithfully,


Dr Marie Tan-Paredes
MBBS, DCH, FRACGP
2813939B

BOIMHC MENTAL HEALTH 3 STEP PROCESS

PART 2 - PLAN & REVIEW

Patient Name	Miss Leila Henshaw	Date of Birth	17/03/2006
GP	Dr Marie Tan-Paredes 0291618086	Outcome Tool Used	K10
Date of Plan	26/07/2024	Date of Review	
Outcome tool result at assessment		Result at review	

	GOAL	PLAN	REVIEW
Problem/Diagnosis	(eg reduce symptoms, improve functioning)	Action/ Task (eg Refer for Allied Health, or pharmacological treatment, or engagement of family and other supports)	
1.General Anxiety Disorder	Identify the stressors Reduce the symptoms Improve functioning Managing negative thoughts	Attend counselling session with psychologist Review after 3-4 session	Psychologist Michelle Hookham GP
2? PTSD	identify the stressors reduce symptoms planning positive activities	Attend counselling session with psychologist Review after 3-4 session	Psychologist - Michelle Hookham GP
3. ADD	identify the stressors coping mechanisms	attend counselling session with psychologist ; psychiatrist Review after 3-4 session	Psychologist - Michelle Hookham GP dr. Butler paediatrician Dr. Naaz

For which Access to Allied Health Service is the person being referred? (Multiple responses allowed)

Diagnostic assessment Yes / Psycho-education Yes / Interpersonal Therapy Yes /

Cognitive Behavioural Therapy (CBT): Behavioural interventions Yes / No Cognitive interventions yes

Other CBT interventions (please specify):

Other - please specify:

If referring for CBT program - Consent form signed by patient Yes /

Relapse Prevention Plan (if appropriate)

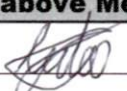
Emergency Care

NSW – 1800 011 511 – Mental Health Line

Patient Education Yes / **Copy of MH plan given to patient** Yes /

Does the patient understand their condition? YES

I understand the above Mental Health Plan and agree to the outlined goals/actions

Patient Signature:  Date: 26.7.24

GP Signature:  Date: 26.7.24

Date for Mental Health Review (between 1 – 6 months): 2 months

MBS Item Numbers for Review by GP: Level C 2574 surgery and 2575 elsewhere; Level D 2577 surgery and 2578 elsewhere.
This document will be maintained in accordance with the relevant Privacy Legislation.

PSYCHOLOGICAL THERAPY SERVICES

Referral Form

This referral is only valid with a PTS Referral Code. To obtain a referral code, GPs and other approved referrers must contact the Nepean Blue Mountains PHN dedicated referral line.

Completed referral form to be sent to the AHP with Mental Health Treatment Plan where indicated below:

Phone: 1800 223 365 Psychological Therapy Services (PTS) dedicated referral line

Date of Referral	Patient Initials	Year of Birth	Patient Gender	Patient Postcode	PTS REFERRAL CODE
26/7/24	LH	2006	F	2758	NBM: 12419

PTS Practitioner Details

Name: Dr Marie Tan-Paredis Contact Number: 91618086
Fax/Email: northrichmond.reception@myhealth.net.au

Attached, please find an assessment for a patient that I wish to refer to you under the Nepean Blue Mountains PHN Psychological Therapy Program for Focussed Psychological Strategies (FPS).

Mental Health Treatment Plan/Review and pension card required unless indicated otherwise.

Please note Aboriginal and/or Torres Strait Islanders can access any PTS stream without a pension card.

- ☐ Seek Out Support (SOS Suicide Prevention) (No HCC or MHTP required)
- ☒ General (New patients only, no HCC required)
- ☐ Disaster Recovery (bushfire/flood/Bondi Junction tragedy) (No HCC or MHTP required)
- ☒ Young people aged 12-25 years (HCC and MHTP required)
- ☐ Children aged 0-11 years (Family HCC and MHTP required)
- ☐ Perinatal (HCC and MHTP required)
- ☐ Aboriginal and/or Torres Strait Islander Peoples (MHTP required)
- ☐ Unpaid Carer of a person with a disability, medical condition, mental illness or frail and aged (HCC and MHTP required)
- ☐ Lesbian, Gay, Bisexual, Transgender, Queer, Intersex (HCC and MHTP required)
- ☐ Co-morbid Alcohol and Other Drugs (HCC and MHTP required)
- ☐ Extended (Individuals aged 25 and over with additional complex trauma) (HCC and MHTP required)

For more information on referral eligibility criteria, please visit <https://www.nbmphn.com.au/pts>

This patient needs to return to me for a review by: _____

The review with the GP is required within 12 months of the referral date

Recommendation at the conclusion of sessions (SOS referrals only):

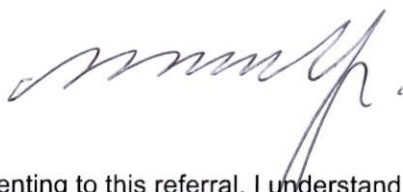
☐ GP review not required. Patient is seeking further referral through Medicare Better Access to Psychiatrists, Psychologists, and General Practitioners. Mental Health Treatment Plan must be attached.

NB: Allied Health Professionals are entirely responsible for ensuring that appropriate MBS item(s) are billed.
<http://www.mbsonline.gov.au/>

☐ GP review required. Patient to return to GP for review.

PATIENT INFORMATION:			
Country of Birth	<input checked="" type="checkbox"/> Australia <input type="checkbox"/> Other (please specify) _____		
Aboriginal/Torres Strait Islander	<input checked="" type="checkbox"/> Neither <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Unknown		
Marital Status	<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married/De facto <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Unknown		
Homelessness	<input checked="" type="checkbox"/> Stable Housing <input type="checkbox"/> Short term/emergency accommodation <input type="checkbox"/> Sleeping rough		
Labour Force Status	<input type="checkbox"/> Employed full time <input checked="" type="checkbox"/> Employed Part time <input type="checkbox"/> Unemployed <input type="checkbox"/> Not in the labour force <input type="checkbox"/> Unknown		
Source of Income	<input checked="" type="checkbox"/> Paid employment <input type="checkbox"/> Disability Support Pension <input type="checkbox"/> Other pension <input type="checkbox"/> Compensation payments <input type="checkbox"/> Other (super, investments, etc.) <input type="checkbox"/> Nil income <input type="checkbox"/> Unknown		
NDIS Participant	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	Preferred Mode of Service Delivery	<input type="checkbox"/> Face to Face <input type="checkbox"/> No preference <input type="checkbox"/> Telehealth
Last outcome measure	<input type="checkbox"/> K10 <input type="checkbox"/> K5 <input type="checkbox"/> SDQ Score: <u>K10 26</u> Date Administered: <u>10/10/24</u>		
Diagnosis	<u>ADD, anxiety ? PTSD. Stress 24</u>		
KEY SUPPORTS: Patient has given consent for GP/Provider to contact support person: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
Name:	<u>Lil Henshaw</u>	Phone:	<u>0437 777 839</u>
Relationship to patient: <u>Aunt - but her carer</u>			
OTHER MENTAL HEALTH PROFESSIONALS CURRENTLY INVOLVED (e.g. psychiatrist, social worker)			
Name:	<u>Dr Butler</u>	Phone:	<u>9832 7515</u>
Name:		Phone:	

GP Signature or Stamp:



Myhealth North Richmond
Dr Marie Tan-Paredes
 MBBS, DCH, FRACGP
 Provider Number: 28139398
 Level 1, North Richmond Village
 6-16 Riverview Street
 North Richmond NSW 2754
 Ph: (02) 9161 8086 Fax: (02) 9161 8087

Patient Consent: By consenting to this referral, I understand that all information in this referral, and any previous referrals (where applicable) including my personal information, will be collected for the primary purpose of delivering care; and for the ongoing monitoring, reporting, evaluation and improvement of services. I consent with the understanding that this information will only be used, disclosed and stored for its primary purpose, between my health service provider(s), the Department of Health, and the Nepean Blue Mountains Primary Health Network (NBMPHN) and affiliated partner organisation(s)*, in accordance with the *Australian Government Privacy Act, 1988*.

* Affiliated partner organisation(s) means those required to support the monitoring, reporting, evaluation and/or clinical governance for the service.

Patient Signature [Signature]

Date

20/7/24

Consent for Patient under 18 years of age:

Parent/Guardian/Carer Name: _____

Contact number: _____

Email: _____

Signature _____

Date _____