PSYCHOLOGICAL THERAPY SERVICES Referral Form

Date of



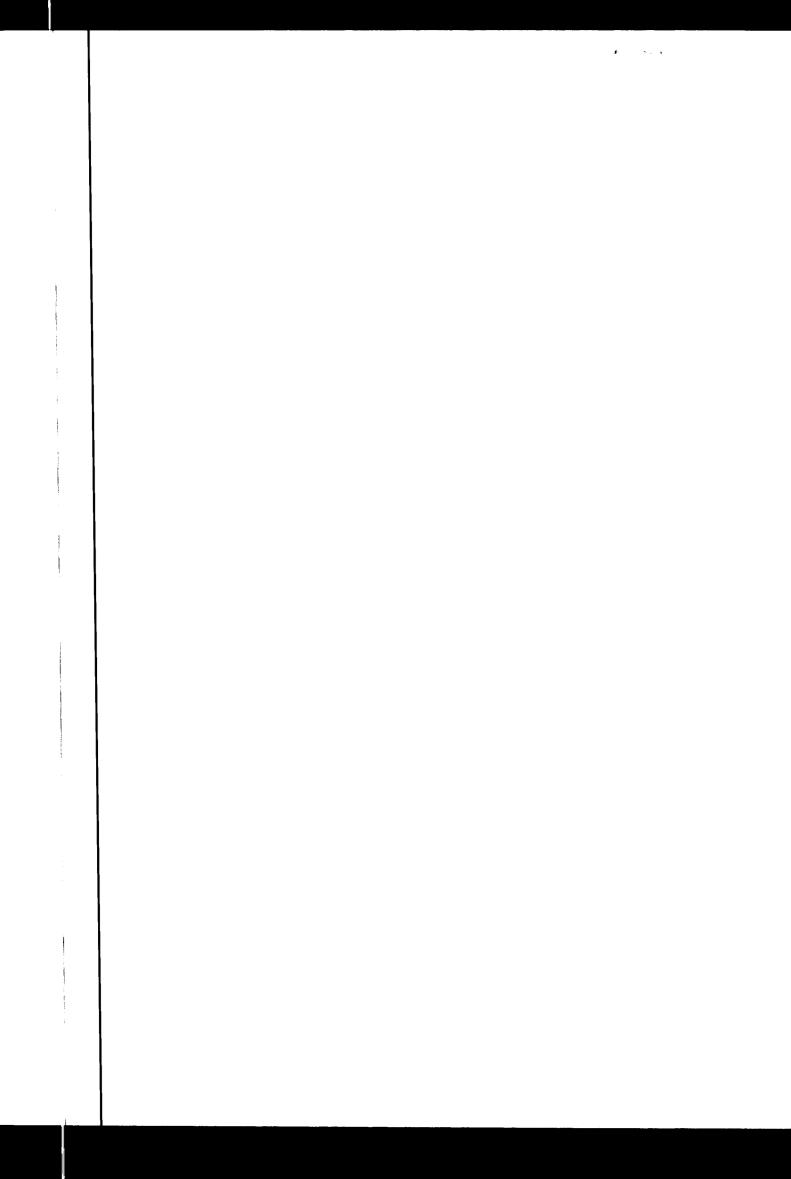


This referral is only valid with a PTS Referral Code. To obtain a referral code, GPs and other approved referrers must contact the Nepean Blue Mountains PHN dedicated referral line.

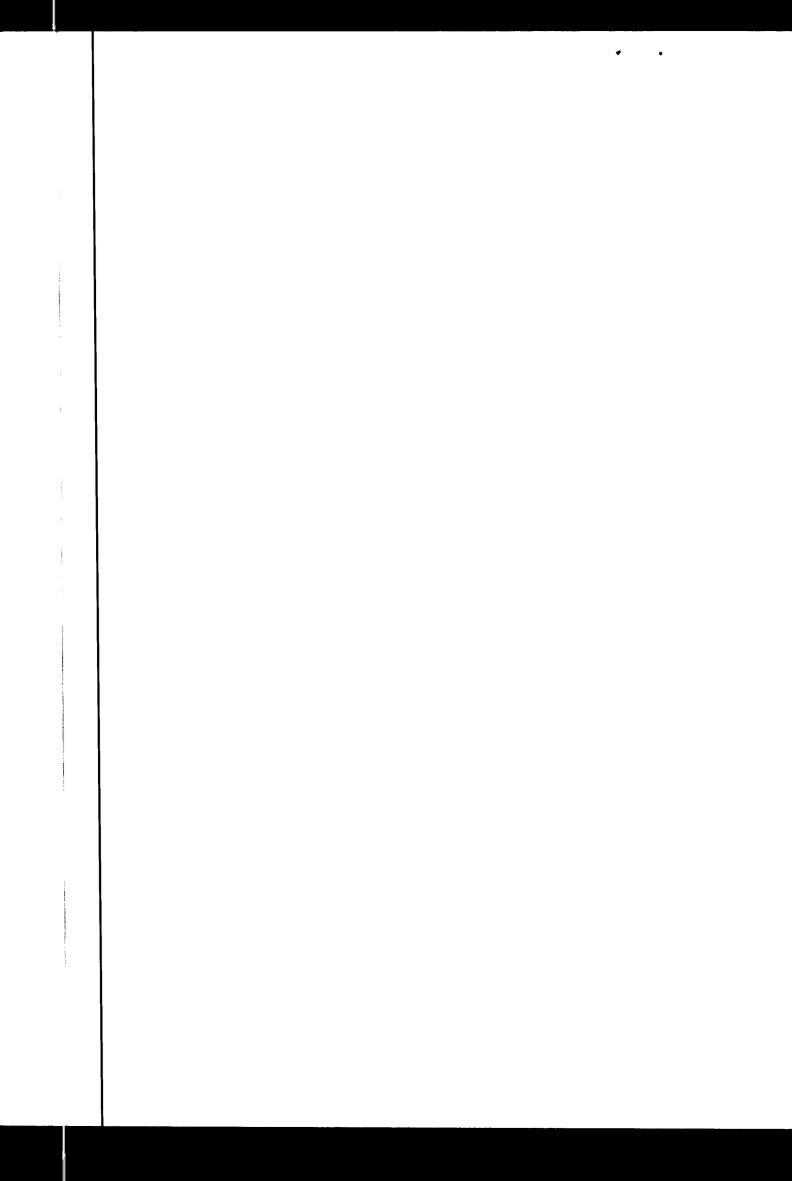
Completed referral form to be sent to the AHP with Mental Health Treatment Plan where indicated below:

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
6/4/25	47	12/8/02		とっこ	NBM: 15497
PTS Practitioner D		Hookt	<u>L</u> MMContact Nu	ımber:	4574425
Fax/Email:					
Attached, please fin Psychological Thera					he Nepean Blue Mountains PHN
					licated otherwise. tream without a pension card.
☐ Seek Out Sup	port (SOS Su	uicide Preventi	ion) (No HCC or N	MHTP required)	
⊈ _General (New	patients on	ly, no HCC re	quired)		
☐ Disaster Reco	overy (bushfir	e/flood) (No H	CC or MHTP requ	uired)	
☐ Young people	aged 12-25	years (HCC ar	nd MHTP required	1)	
☐ Children aged	l 0-11 years (Family HCC a	nd MHTP required	(t	
□ Perinatal (HC	C and MHTP	required)			
☐ Aboriginal and	d/or Torres S	trait Islander P	eoples (MHTP red	quired)	
☐ Unpaid Carer o	f a person with	a disability, me	dical condition, men	tal illness or frail and	l aged (HCC and MHTP required)
□ Lesbian, Gay	, Bisexual, Tr	ansgender, Qı	ueer, Intersex (HC	C and MHTP requ	ired)
☐ Co-morbid Ale	cohol and Oth	ner Drugs (HC	C and MHTP requ	uired)	
☐ Extended (Inc	dividuals aged	d 25 and over	with additional cor	nplex trauma) (HC	CC and MHTP required)
For more informa	tion on referra	al eligibility crit	eria, please visit <u>b</u>	nttps://www.nbmph	n.com.au/pts
This patient need					
☐ GP review r	not required. F	Patient is seek	ing further referra	S referrals only) I through Medicare al Health Treatmen	
NB: Allied Health http://www.mbso			responsible for en	suring that approp	riate MBS item(s) are billed.
☐ GP review re	equired. Patie	ent to return to	GP for review.		



PATIENT INFORM	MATION:					
Country of Birth	☑ Australia □ Other (please specify)					
Aboriginal/Torres Strait Islander	□ Neither □ Aboriginal □ Torres Strait Islander □ Both □ Unknown					
Marital Status	☐ Never Married ☐ Married/De facto ☐ Widowed ☐ Divorced ☐ Separated ☐ Unknown					
Homelessness	☐ Stable Housing ☐ Short term/emergency accommodation ☐ Sleeping rough					
Labour Force Status	☐ Employed full time ☐ Employed Part time ☑ Unemployed ☐ Not in the labour force ☐ Unknown					
Source of Income	· •	☐ Paid employment ☐ Disability Support Pension ☐ Other pension ☐ Compensation payments ☐ Other (super, investments, etc.) ☐ Nil income ☐ Unknown				
NDIS Participant	☐ Yes ☐ No ☐ Unknown	Preferred Mode of Service Delivery	☐ Face to Face ☐ No ☐ Telehealth preference			
Last outcome measure	☐ K10 ☐ K5 ☐ SDQ Score: _	□ K10 □ K5 □ SDQ Score: 3 3 Date Administered: 6 4 4 1				
Diagnosis						
KEY SUPPORTS	: Patient has given consent for	The State of State of the State	act support person: ☐ Yes ☐ No			
Name: Sayar	n Dauy	Phone: 043	34585243			
Relationship to par	tient: MUM					
OTHER MENTAL	HEALTH PROFESSIONALS C	URRENTLY INVOLV	ED (e.g. psychlatrist, social worker)			
Name:		Phone:				
Name:		Phone:	Phone:			
GP Signature or S	Stamp: DR. S. VIRK CHMOND MARKETPLACE MEL Shop 46/78 March Str Richmond NSW 27 96533GB Ph: 45	reet V0412	<u></u>			
referrals (where appli care; and for the ong- understanding that the health service provide	icable) including my personal info oing monitoring, reporting, evalua iis information will only be used, d er(s), the Department of Health, a	rmation, will be collect tion and improvement lisclosed and stored fo and the Nepean Blue M	nation in this referral, and any previous ed for the <u>primary purpose</u> of delivering of services. I consent with the r its primary purpose, between my dountains Primary Health Network stralian Government Privacy Act, 1988.			
clinical governanc	ce for the service.	uired to support the m	onitoring, reporting, evaluation and/or			
Patient Signat	ture pday	Date	6/4/15			
	nt under 18 years of age:		V			
Parent/Guardi	an/Carer Name:	No.				
Contact numb	er:	Email:				
Signature		Date				



Richmond Marketplace Medical Centre

Shop 46, Richmond Marketplace ABN: 28 325 871 904 78 March Street RICHMOND NSW 2753

Phone: (02) **4578 4800** Fax: (02) 4578 3300

06/04/2025

Dr SUKHVINDER VIRK 096533GB

Ms Michelle Hookham Old Hawkesbury Hosoutal 6 Christie Street Windsor 2756 45774435

Dear Michelle,

Re: Miss Paris Davy 0402731459

Thank you for seeing Miss Paris Davy, age 19 yrs, for an opinion and continued management. Smoking Hx: Non smoker

Current Problem:

Anxiety/ depression. For 6 sessions of counselling under medicae.

Past History:

28/11/2018 Back pain

B/L pars defect of L5 ,scoliosis I5/s1 spondylolithesis 1 mm

28/11/2018 Flat feet

Talipes

Allergies:

Amoxil

RASH

Strawberries

Current Medications:

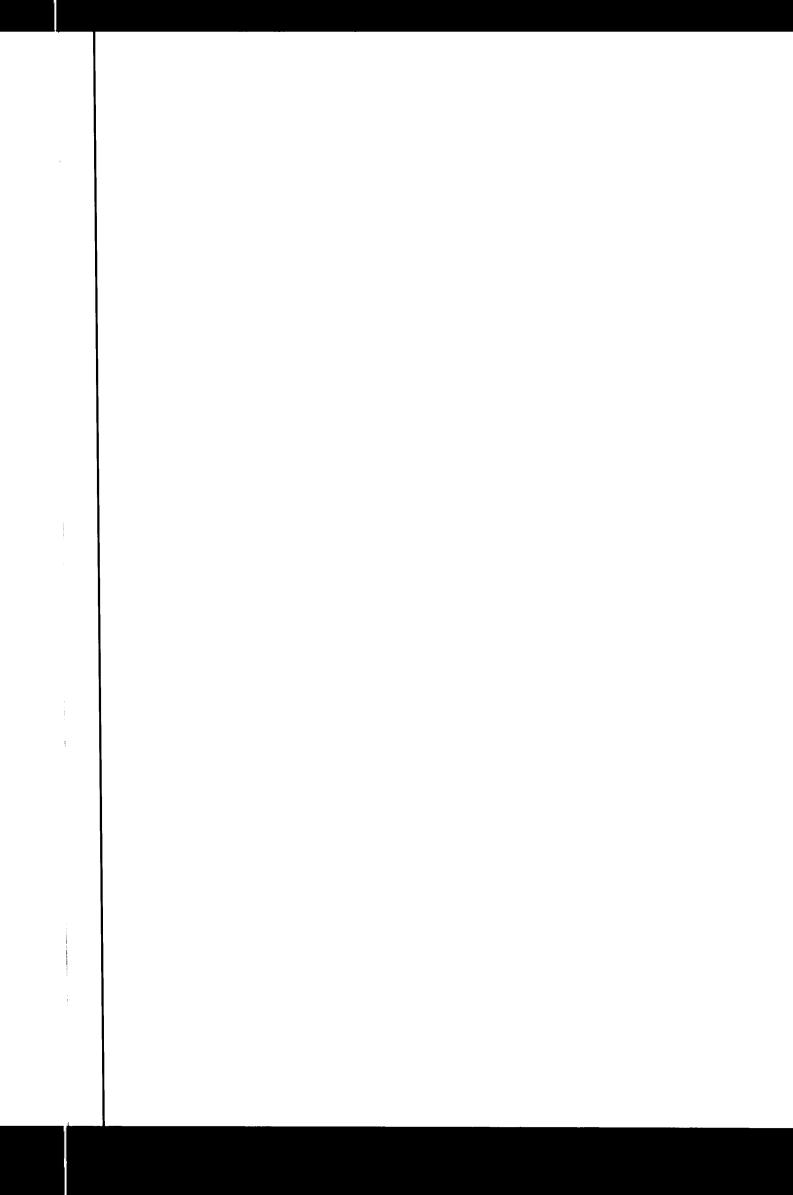
Mirtanza 15mg Tablets Ostelin Vitamin D 1000IU Gel Capsule 1/2 Before bed. 1 Capsule Daily.

I seek your opinion regarding further management.

Thankyou for your care and assistance. I shall await your reply.

Kind Regards,

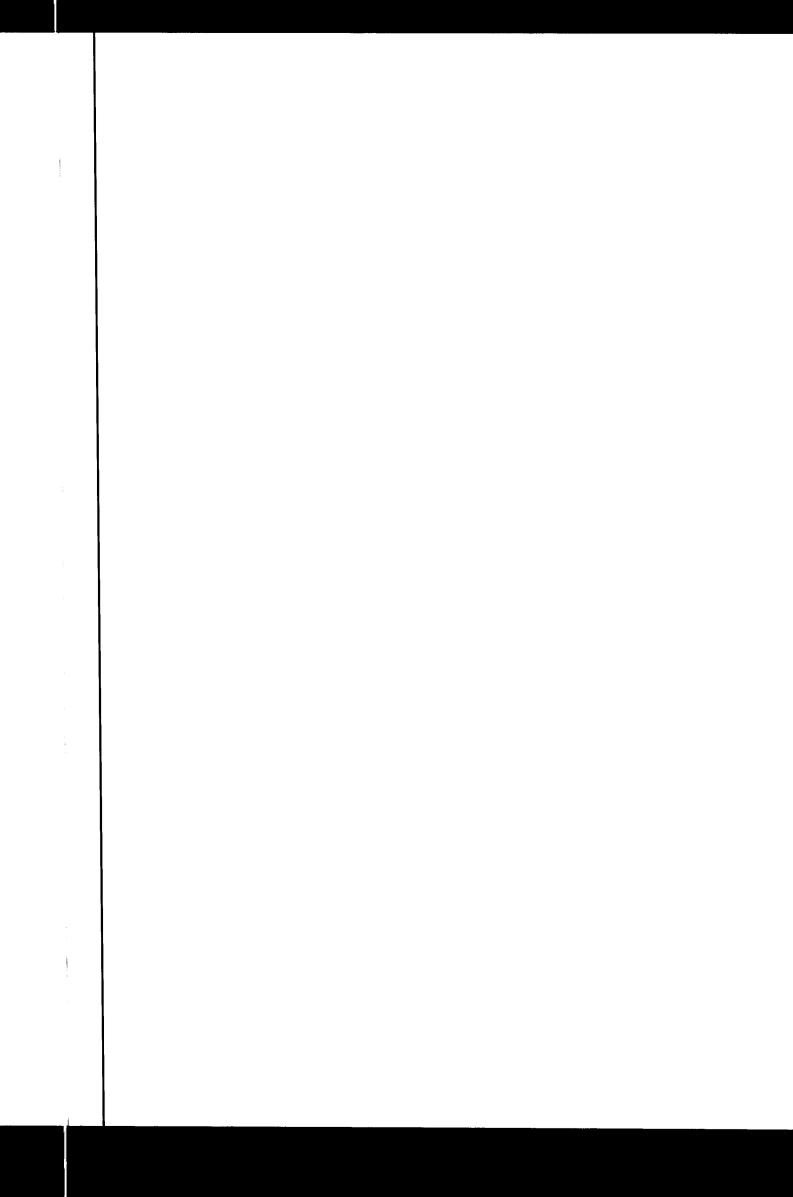
J'



Dr SUKHVINDER VIRK Shop 46, 78 March St Richmond 2753

Richmond Marketplace Medical Centre

PLEASE NOTE: ALL CORRESPONDENCE CAN BE SENT VIA HEALTHLINK EDI CODE: ricmktmc



GP MENTAL HEALTH CARE PLAN

ITEM: 2715

From:

Richmond Marketplace Medical Centre Shop 46, 78 March Street, Richmond 2753 Ph: (02) 45784800 Fax: (02) 45783300

Date:

06/04/2025

Patient Name:

Miss Paris Davy

<u>Medicare No:</u>

2692230115

DOB:

15/08/2005

Anxety/ depression

3 4		•	•	. •
/VI	pntal	Status	Examin	atıon
***	Cittut	C) e ce e e co	Lower	weever.

Appearance	e and General B	Behaviour	Mood (Depress	sed/Labile)
⊠Normal	□Other:		□Normal	☑depressed-Anxious:
Thinking (C	Content/Rate/Disturb	oances)	Perception (H	Hallucinations, etc.)
⊠Normal	□Other:		⊠Normal	Other:
Sleep (Initial	Insomnia/Early Mo	rning Wakening)	Cognition (Le	evel of Consciousness/Delirium/Intelligence)
□Normal	⊠Insomnia	□ Excessive	⊠Normal	Other:
Appetite (Di	isturbed Eating Patte	erns)	Attention/Co	ncentration
□Normal	⊠ Reduced	□ Overeating	■Normal	⊠reduced:
Motivation/	Energy		Memory (Sho	rt and Long Term)
□Normal	⊠ Not Motiva	ated	⊠Normal	□reduced:
Insight			Anxiety Sym	ptons (Physical and Emotional)
⊠Normal	□Other:		□Normal	⊠Anxious
Orientation	(Time/Place/Perso	n)	Speech (Volum	ne/Rate/Content)
⊠Normal	□Other:		⊠Normal	Other:
Suicidal Ide	eation		Suicidal Inte	nt
⊠Yes	□No		□Yes	⊠No.

Assessment Plan & Discussion

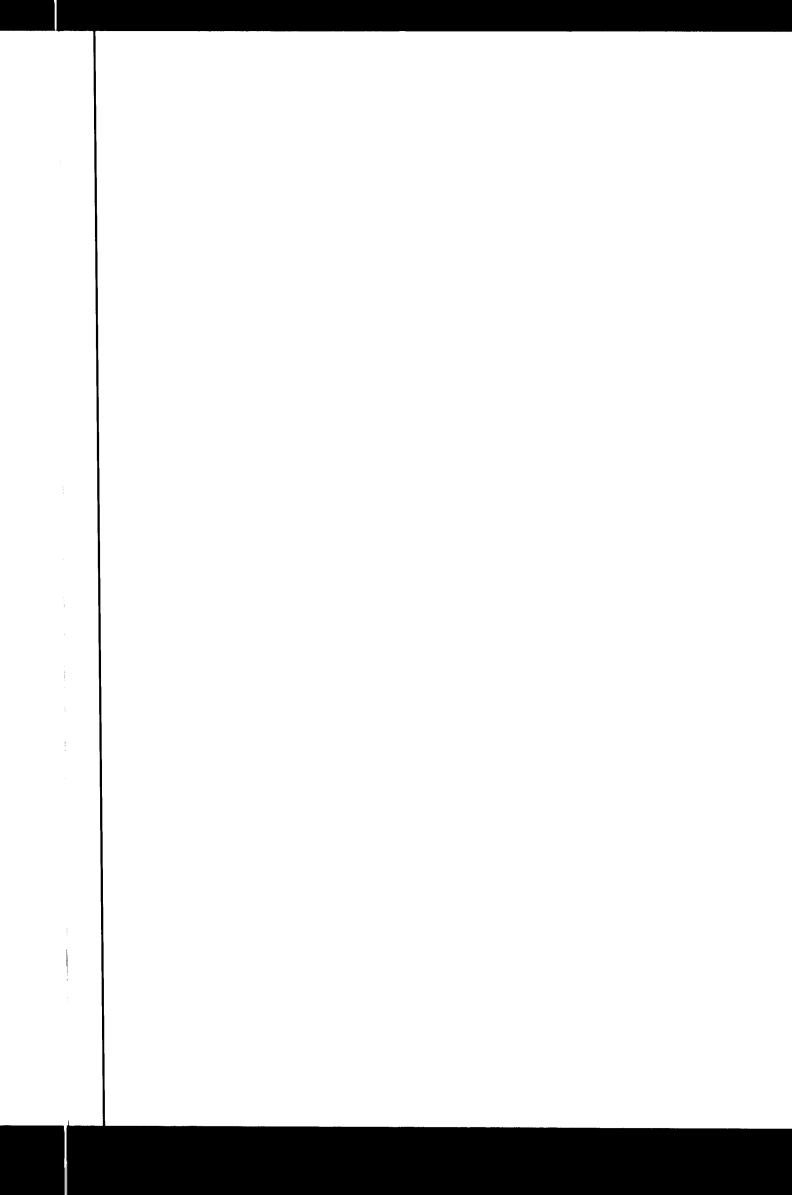
Anxiety/ depression

Goal:

- Counselling
- Learning stratgeries to be able to deal with all psychological issues

Provision of Psycho Education:

• Material regarding Depression; Anxiety & Bipolar



Plan for Crisis

• Life Line Penrith Regional Centre Ph: (02) 131114

• Mental Health Crisis Team Ph: 1800 011 511

• Hawkesbury Hospital Ph: (02) 4560 5555

• Surgery Phone No: (02) 4578 4800

Surgery Facsimile No: (02) 4578 3300

Referral to Psychologist/Psychiatrist:

referral to Michelle Hookhma

Review Date:

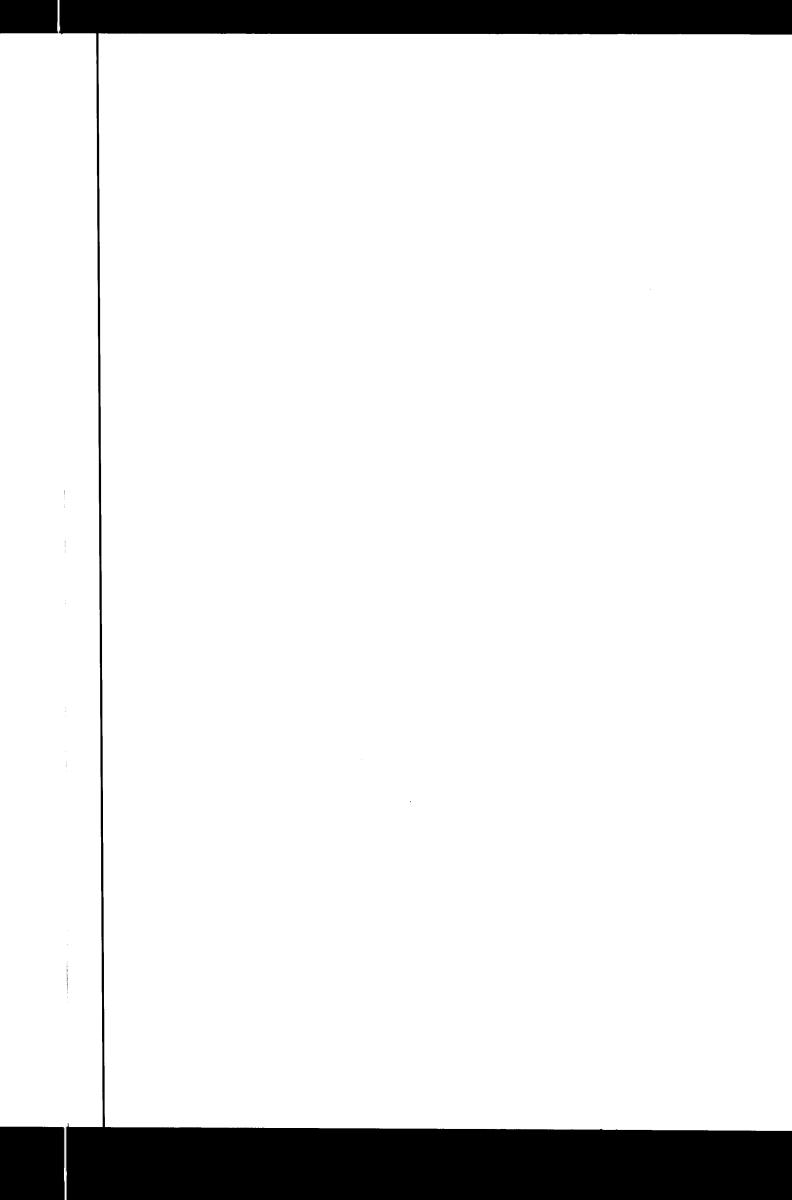
2 months

<u>Doctor</u>......Dr SUKHVIKDER VIRK

096533GB

Richmond Marketplace Medical Centre Shop 46, 78 March Street, Richmond 2753

Ph: (02) 45784800 fax: (02) 45783300



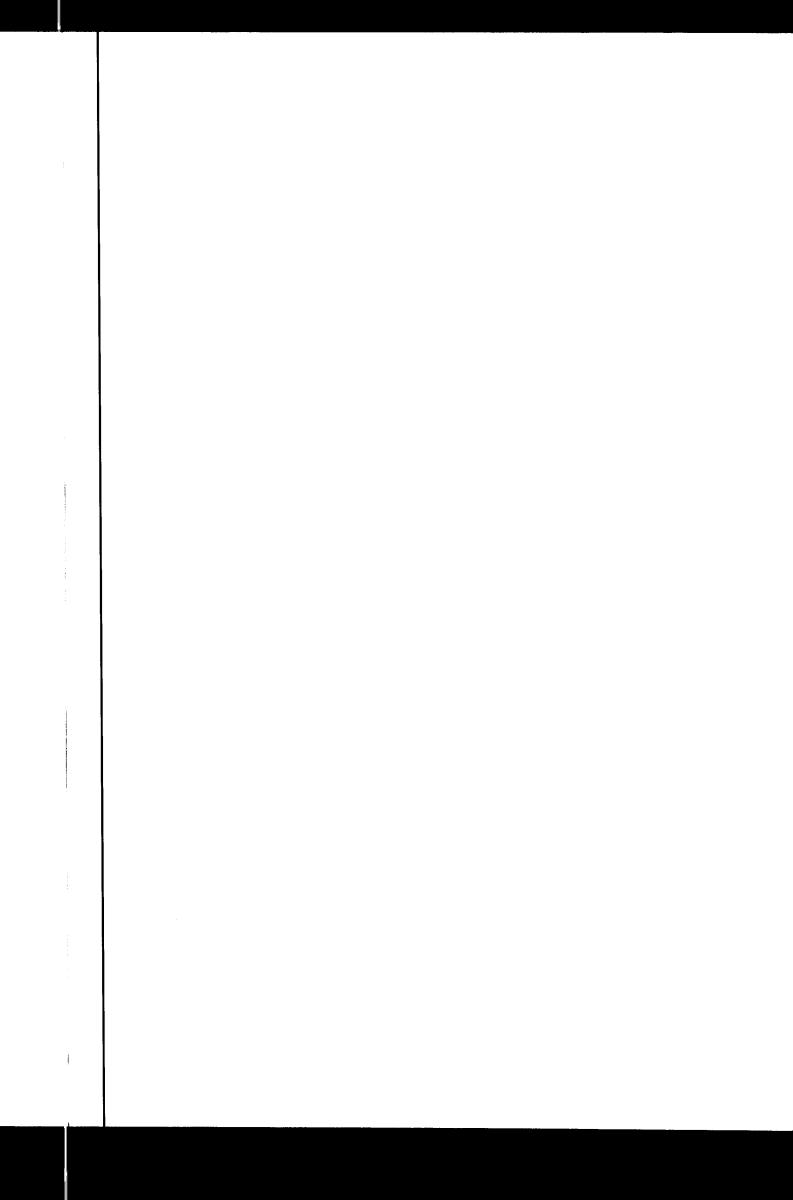
K10

For all questions, please fill in the appropriate response with an "X" in the space provided.

The maximum score is 50 indicating severe distress and the minimun score is 10 indicating no distress.

Questions 3 and 6 are not asked if the proceeding question was 'none of the time' in which case questions 3 and 6 would automatically receive a score of one.

	1	2	3	4	5	
In the past 4 weeks	None of the time	A little of the time	Some of the time		All the time	Score
About how often did you feel tired out for no good reason?				X		
About how often did you feel nervous?				X		
3. About how often did you feel so nervous that nothing could calm you down?			×			
4. About how often did you feel hopeless?					X	
5. About how often did you feel restless of fidgety?	×					
6. About how often did you feel so restless you could not sit still?	\propto					
7. About how often did you feel depressed?			×			
8. About how often did you feel that everything is an effort?		\times				
9. About how often did you feel so sad that nothing could cheer you up?					\checkmark	
10. About how often did you feel worthless?					X	
	Today's Date: 6/4/2025				Total Score	3)



Patient Health Summary

Name: Miss Paris Davy

Address: 37 Town Street

Richmond 2753

D.O.B.: 15/08/2005

Record No.: 68589

Home Phone: Work Phone:

Mobile Phone: 0402731459

Printed on 7th April 2025

RICHMOND MARKETPLACE MEDICAL

CENTRE

Shop 46, 78 March St

Richmond 2753

0245784800

Allergies/Adverse reactions:

Amoxil

RASH

Strawberries

Current Medications:

Mirtanza 15mg Tablets

Ostelin Vitamin D 1000IU Gel Capsule

½ Before bed.

1 Capsule Daily.

Active Past History:

28/11/2018

Back pain

B/L pars defect of L5, scoliosis 15/s1 spondylolithesis 1 mm

28/11/2018 Flat feet **Talipes**

Inactive Past History:

Not recorded.

Immunisations:

10/07/2021 Nimenrix (Meningococcus ACWY)

