PSYCHOLOGICAL THERAPY SERVICES
Referral Form

phn NEPEAN BLUE MOUNTAINS An Australian Government Initiative

Wentworth Healthcare
Blue Mountains | Hawkesbury | Lithgow | Penrith

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

PTS Practitioner Michelle Hookham

NBM 16692

Date of Referral	Patient Initials	Year of Birth	Patient Gender	Patient Postcode	PTS REFERRAL CODE
5/8/2025	A	25/5/2011	F	2765.	NBM: 16692.

Ph- 02 45774935

PTS Practitioner Details

Name: Aimee-leigh Dixon Contact Number: 04 11047033

Fax/Email: _____

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, HCC and 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: 6 months.
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:			
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 preference ☐ Telehealth
Last outcome measure	☐ K10 ☐ K5 ☐ SDQ Score: _____ Date Administered: Paediatric Symptom Check List.		
Diagnosis	Depression + possible eating disorder.		

KEY SUPPORTS: Patient has given consent for GP/Provider to contact support person(s): ☐ Yes ☐ No	
Name: Jemma Dixon	**Phone:** 04 11 04 7033
Relationship to patient: Mother	
Name:	**Phone:**
Relationship to patient:	

OTHER MENTAL HEALTH PROFESSIONALS CURRENTLY INVOLVED (e.g. psychiatrist, social worker)	
Name:	**Phone:**
Name:	**Phone:**

GP Signature or Stamp:

Dr Myo [illegible]ar Aung
Our Medical Marsden Park
1/9 Hollinsworth Rd,
Marsden Park NSW 2765
T 02 8042 0485
Provider No: 463919CB

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 _____ **Date** _____

Consent for Patient under 18 years of age:

Parent/Guardian/Carer Name: Jemma Dixon

Contact number: 0411047033 **Email:** jemmadixon199@gmail.com

Signature _____ **Date** 05/08/2025

Mental Health Programs

phn SOUTH WESTERN SYDNEY
An Australian Government Initiative

Mental Health Central Intake
Enquiries 1300 797 746 (1300 SWSPHN) **Referrals confidential fax 4623 1796**

Child's Name: Aimee - Leigh **DOB:** 25/5/2011
Form completed by: Dixon **Relationship to Child:**
Date completed: 5/8/2025.

Please tick under the heading that best describes your child.

Scoring The item ratings "Never", "Sometimes" and "Often" are scored "0", "1" and "2" respectively.
Sum the scores for individual items (sub-total) and then calculate the total score

		NEVER (0)	SOMETIMES (1)	OFTEN (2)
1	**Feels sad, unhappy**			✓
2	Feels hopeless			✓
3	**Is down on self**			✓
4	Worries a lot			✓
5	**Seem to be having less fun**		✓	
6	Fidgety, unable to sit still			✓
7	**Daydreams too much**			✓
8	Distracted easily			✓
9	**Has trouble concentrating**			✓
10	Acts as if driven by a motor			✓
11	**Fights with other children**		✓	
12	Does not listen to rules		✓	
13	**Does not understand other people's feelings**	✓		
14	Teases others	✓		
15	**Blames others for his/her troubles**	✓		
16	Refuses to share			✓
17	**Takes things that do not belong to him/her**	✓		
	Sub-total:			

Total = 23

A score of 15 or more suggests a need for assessment by a mental health professional.

Adapted from the Paediatric Symptom Checklist developed by the Massachusetts General Hospital 1988
http://www.massgeneral.org/psychiatry/services/psc_use.aspx

GP MENTAL HEALTH TREATMENT PLAN – VERSION FOR CHILDREN

Notes: *This form is designed for use with the following MBS items. Users should be familiar with the most recent item definitions and requirements.*

MBS ITEM NUMBER: 2700 2701 2715 2717

Major headings are ***bold;*** *prompts to consider lower case. Response fields can be expanded as required.*
Underlined items of either type are mandatory for compliance with Medicare requirements.

This document is not a referral letter. A referral letter must be sent to any additional providers involved in this mental health treatment plan.

Here is a printable version of the E-MENTAL HEALTH PATIENT INFORMATION BROCHURE ***for your patients***

CONTACT AND DEMOGRAPHIC DETAILS

GP name	**Dr Myo Aung**	**GP phone**	**0280420485**
GP practice name	**Our Medical Home Marsden Park**	**GP fax**	**0280420486**
GP address	**1/9 Hollinsworth Road Marsden Park 2765**	**Provider number**	**463919CB**
Relationship	**This person has been my patient since**		
	and/or		
	This person has been a patient at this practice since		
Patient surname	**Dixon**	**Date of birth** (dd/mm/yy)	**25/05/2011**
Patient first name(s)	**Aimee-liegh**	**Preferred name**	**Aimee-liegh**
Gender	**Female** Self-identified gender:		
Patient address	**69 Pecan Crescent Grantham Farm 2765**		
Patient phone	Preferred number: Can leave message?	Alternative number: Can leave message?	
Medicare No.	**2840943152**	**Healthcare Card/Pension No.**	

Parent/guardian details			**Has patient consented for this Treatment Plan to be released to parents/guardians?**
First parent/guardian: Jemma Dixon	Relationship: mother	Phone number 1: 0411047033 Phone number 2:	With the following restrictions:

Second parent/guardian:	Relationship: **<1. Parent/guardian relationship:>**	Phone number 1: **<1. Parent/guardian phone number 1:>** Phone number 2: **<1. Parent/guardian phone number 2:>**	With the following restrictions:
Emergency contact person details			**Has patient consented for this healthcare team to contact emergency contacts?**
First contact:	Relationship:	Phone number 1: Phone number 2:	
Second contact:	Relationship:	Phone number 1: Phone number 2:	

Schooling (if applicable)

Current school level		**Name of school/pre-school**	
Salient school factors Consider: • Prior disruption to schooling • Current frequency of school attendance • Ability to start and finish homework • Peer relationships • Bullying • Traumatic school community events	**bullying online and face to face , far behind with study**		

Patient/guardian consent to discuss GPMHTP with the following members of school community:

	Role	Name(s)	Phone
Yes	**Principal**	**Miss**	
Yes	**Assistant Principal(s)**		
Yes	**Teacher(s)**		
Yes	**School Counsellor(s)**		
Yes	**Other**		

SALIENT COMMUNICATION AND CULTURAL FACTORS

Language spoken at home	English	Other:
Interpreter required	Nil	Yes, Comments:
Country of birth	Australia	Other:
Other communication issues	**Nil**	
Other cultural issues	**Nil**	

PATIENT ASSESSMENT – MENTAL HEALTH	
Reasons for presenting Consider: • What are the patient's current mental health issues? • Requests and hopes	**low mood and ? eating disorder**
History of current episode Consider: • Symptom onset, duration, intensity, time course	**since few months ago**
Patient history Consider:	
• Mental health history	**self harm thought**
• Salient social history	school bullying
• Salient medical/biological history • ♀ - menarche, menstruation, pregnancy, menopause	**NAD**
• Salient developmental issues	
Family history of mental illness Consider: • Family history of suicidal behaviour • Genogram	
Current domestic and social circumstances Consider: • Living arrangements • Social relationships • Occupation	**lives with mother and younger sister**
Salient substance use issues Consider: • Nicotine use • Alcohol use • Illicit substances • Is patient willing to address the issues?	**Nil**
Current medications Consider: • Dosage, date of commencement, date of change in dosage • Reason for the prescription • Are there other practitioners involved in the prescription of medication? • Are there issues with compliance or misuse?	Nil

History of medication and other treatments for mental illness Consider: • Past referrals • Effectiveness of previous treatments • Side-effects and complications associated with previous treatments • Patient's preference for medications	
Allergies	Nil known.
Relevant physical examination and other investigations	
Results of relevant previous psychological and developmental testing	
Other care plan e.g. GP Management Plans and Team Care Arrangements; Wellness Recovery Action Plan	If yes Specify:

Comments on Current Mental State Examination

Consider: • Appearance, cognition, thought process, thought content, attention, memory, insight, behaviour, speech, mood and affect, perception, judgement, orientation. • Appropriateness of Mini Mental State Examination for patients over 75 years or if otherwise indicated	reduced eye contact, dress well, no hallucination, sleep- poor, appettie- reduced, mood and affect- low, judgement and insight- poor, alert , poort rapport

Risk assessment
If high level of risk indicated, document actions taken in Treatment Plan below
Consider:
- Does the patient have a timeline for acting on a plan?
- How bad is the pain/distress experienced?
- Is it interminable, inescapable, intolerable?

	Ideation/ thoughts	Intent	Plan
Suicide	Y	N	N
Self harm	Y	N	N
Harm to others	N	NN	n

Comments or details of any identified risks

Assessment/outcome tool used, except where clinically inappropriate.	**paediatric symtpom check list**

Date of assessment	**5/08/2025**
Results	23 Copy of completed tool provided to referred practitioner
Provisional diagnosis of mental health disorder Consider conditions specified in the ICPC, including: • Depression • Bipolar disorder • Other mood disorders • Anxiety disorders • Panic disorder • Phobic disorders • Post-traumatic stress disorder • Schizophrenia • Other psychotic disorders • Adjustment disorder • Dissociative disorders • Eating disorders • Impulse-control disorders • Sexual disorders • Sleep disorders • Somatoform disorders • Substance-related disorders • Personality disorders • Unknown	depression and possible eating disorder
Case formulation Consider: • Predisposing factors • Precipitating factors • Perpetuating factors • Protective factors	
Other relevant information from carer/informants Consider: • Specific concerns of carer/family • Impact on carer/family • Contextual information from members of patient's community • Other content from individuals other than the patient	
Any other comments	

PLAN				
		Actions		
Identified issues/problems Consider: •	**Goals** Consider: •	**Treatments & interventions** Consider: •	**Referrals** Consider:	**Any role of carer/support person(s)** Consider: •
Issue 1: **depression and possible eating disorder**	to improve self esteem to develoip strategies for coping with stress to develop positive thinking habit to reduce anxiety symtpoms to improve positive body image control	psychotherapy CBT	psychologist	
Issue 2:				
Issue 3:				

Intervention/relapse prevention plan (if appropriate at this stage) Consider: • Identify warning signs from past experiences • Note arrangements to intervene in case of relapse or crisis • Other support services currently in place • Note any past effective strategies	Preparation of plan for delegation of patient's responsibilities (e.g., care for dependants, pets)	
Psycho-education provided if not already addressed in "treatments and interventions" above?	Yes	No
Plan added to the patient's records?	Yes	No

Other healthcare providers and service providers involved in patient's care
(e.g. psychologist, psychiatrist, social worker, occupational therapist, other GPs, other medical specialists, case worker, community mental health services)

Role	Name	Address	Phone

COMPLETING THE PLAN

On completion of the plan, the GP may record (tick boxes below) that s/he has:	Date plan completed
discussed the assessment with the patient discussed all aspects of the plan and the agreed date for review offered a copy of the plan to the patient and/or their carer (if agreed by patient)	**5/08/2025**

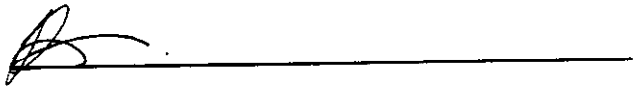
RECORD OF PATIENT CONSENT

I, Aimee-Leigh Dixon *(name of patient)*, agree to information about my health being recorded in my medical file and being shared between the General Practitioner and other health care providers involved in my care, as nominated above, to assist in the management of my health care. I understand that I must inform my GP if I wish to change the nominated people involved in my care.

I understand that as part of my care under this Mental Health Treatment plan, I should attend the General Practitioner for a review appointment at least 4 weeks after but within 6 months after the plan has been developed.

I consent to the release of the following information to the following carer/support and emergency contact persons:

Name	Assessment		Treatment Plan	
	Yes	No	Yes	No
	☐ with the following limitations:	☐	☐ with the following limitations:	☐
	☐ with the following limitations:	☐	☐ with the following limitations:	☐



(Signature of patient)

5 / 8 / 2025

(Date)

I, _____, have discussed the plan and referral(s) with the patient.

(Full name of GP)

5/8/2025.

(Signature of GP) (Date)