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
14/08/2025	**CM**	27/06/1991	Female	2756	**NBM: 16779**

PTS Practitioner Details

Name: Michelle Hookham Contact Number: 45 774435

Fax/Email: health@michellehookham.com.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.
(Mark relevant option with 'X')

	Seek Out Support (SOS Suicide Prevention) **(No HCC or MHTP required)**
	General **(New patients only, no HCC required)**
	Disaster Recovery (bushfire/flood/Bondi Juncion 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)
X	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):

(Answer relevant option with 'YES' or 'NO')

GP review required. Patient to return to GP for review	YES / NO
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/	YES / NO

PATIENT INFORMATION:			
Country of Birth	27/06/1991		
Aboriginal/Torres Strait Islander	Yes - Aboriginal		
Marital Status			
Homelessness			
Labour Force Status			
Source of Income			
NDIS Participant		**Preferred Mode of Service Delivery**	
Last outcome measure *(Mark relevant option with 'X')*	☐ K10 ☐ K5 ☐ SDQ	Score:_____ Date Administered:_____	
Diagnosis			

KEY SUPPORTS: Patient has given consent for GP/Provider to contact support person: Yes / No	
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 Jessie Estrera 242a George Street Windsor 2756

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: _____

Contact number: _____ **Email:** _____

Signature _____ **Date** _____

GP MENTAL HEALTH TREATMENT PLAN – VERSION FOR ADULTS

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 Jessie Estrera** **242a George Street** **Windsor 2756**	**GP phone**	**0290538861**
GP practice name	**Beyond Healthcare Family Practice**	**GP fax**	**0290538864**
GP address	**242a George Street** **Windsor 2756**	**Provider number**	**5301618H**
Relationship	**This person has been my patient since**		**11/08/2025**
	and/or		
	This person has been a patient at this practice since		**11/08/2025**
Patient surname	**Mifsud**	**Date of birth** (dd/mm/yy)	**27/06/1991**
Patient first name(s)	**Chantel**	**Preferred name**	**Chantel**
Gender	**Female** ☐ Self-identified gender:		
Patient address	**40 Cox Street** **South Windsor 2756**		
Patient phone	Preferred number: Can leave message?	Alternative number: Can leave message?	
Medicare No.	**2663169104**	**Healthcare Card/Pension No.**	**205730339H**
Highest level of education completed	Comments:		

Carer/support person contact details			**Has patient consented for this healthcare team to contact carer/support persons?**
First contact:	Relationship:	Phone number 1: Phone number 2:	With the following restrictions:

Second contact:	Relationship:	Phone number 1: Phone number 2:	With the following restrictions:
Emergency contact person details			**Has patient consented for this healthcare team to contact emergency contacts?**
First contact: **Janet Mifsud**	Relationship: **Mother**	Phone number 1: **0432666080** Phone number 2:	
Second contact: **Janet Mifsud**	Relationship: **Mother**	Phone number 1: **0432666080** Phone number 2:	

SALIENT COMMUNICATION AND CULTURAL FACTORS		
Language spoken at home		Other:
Interpreter required		Yes, Comments:
Country of birth	Australia	Other:
Other communication issues		
Other cultural issues		

PATIENT ASSESSMENT – MENTAL HEALTH	
Reasons for presenting Consider: • What are the patient's current mental health issues? • Requests and hopes	Anxiety and depression
History of current episode Consider: • Symptom onset, duration, intensity, time course	
Patient history Consider:	
• Mental health history	Anxiety and depression
• Salient social history	
• Salient medical/biological history • ♀ - menarche, menstruation, pregnancy, menopause	
• Salient developmental issues	
Family history of mental illness Consider: • Family history of suicidal behaviour • Genogram	Father - anxiety/ depression, alcoholic (passed away 2 years ago)
Current domestic and social circumstances Consider: • Living arrangements • Social relationships • Occupation	Live at home with partner and 2 kids (13yo and 14yo) Unemployed, on Centrelink
Salient substance use issues Consider: • Nicotine use • Alcohol use • Illicit substances • Is patient willing to address the issues?	Smokes 20 cigarettes since 13yo ETOH 5-10 std drinks on weekends
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?	

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	Antidepressant 4 years ago - unrecalled name
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 <u>Mental State Examination</u>

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	Appearance: Dressed appropriately Behaviour: Cooperative, good eye contact, good rapport Speech: Spontaneous, low rate and volume Affect: Euthymic Mood: Low mood Thought: Intact Perception: Nil depersonalisation/ derealisation/ illusions/ hallucinations Cognition: Oriented Insight: Intact Judgment: Intact Risks: Nil suicidal ideations, nil thoughts of self harm or harm to others

<u>Risk assessment</u>
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	Nil		
Self harm	Nil		
Harm to others	Nil		

Comments or details of any identified risks

<u>Assessment/outcome tool used,</u> except where clinically inappropriate.	K-10 **K-10**

Date of assessment	11/08/2025
Results	39 ☑ 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	
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

Identified issues/problems Consider: • As presented by patient • Developed during consultation • Formulated by GP	**Goals** Consider: • Goals made in collaboration with patient • What does the patient want to see as an outcome from this plan? • Wellbeing, function, occupation, relationships • Any reference to special outcome measures • Time frame	**Actions** **Treatments & interventions** Consider: • psychological interventions o face to face o internet based • • Suggested psychological interventions • Medications • Key actions to be taken by patient • Support services to achieve patient goals • Role of GP • Psycho-education • Time frame	**Referrals** Consider: • Practitioner, service or agency—referred to whom and what for • Specific referral request • referral to internet mental health programs for education and/or specific psychotherapy • • Opinion, planning, treatment • Case conferences • Time frame	**Any role of carer/support person(s)** Consider: • Identified role or task(s), e.g. monitoring, intervention, support • Discussed, agreed, negotiated with carer? • Any necessary supports for carer • Time frame
Issue 1: Anxiety/ Depression	Identify triggers Cope with symptoms Able to cope/ deal with emotions	CBT Medication if necessary Cognitive behavioural therapy	Psychologist 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)	**11/08/2025**

RECORD OF PATIENT CONSENT

I, _____*(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) *(Date)*

I, **DR. JESSIE PEARL ESTRERA**, have discussed the plan and referral(s) with the patient.

(Full name of GP)

_____ _____/_____/_____

(Signature of GP) *(Date)*

REVIEW	
MBS ITEM NUMBER: ☐ 2712 ☐ 2719	
Planned date for review with GP (initial review 4 weeks to 6 months after completion of plan)	
Actual date of review with GP	
Assessment/outcome tool results on review, except where clinically inappropriate	
Comments Consider: • Progress on goals and actions • Have identified actions been initiated and followed through? e.g. referrals, appointments, attendance • Checking, reinforcing and expanding education • Communication • Where appropriate, communication received from referred practitioners • Modification of treatment plan if required	
Intervention/relapse prevention plan (if appropriate) 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	