

PATIENT INFORMATION			
Marital Status	<input type="checkbox"/> Never Married <input checked="" 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 checked="" type="checkbox"/> Face to Face <input type="checkbox"/> No preference <input type="checkbox"/> Telehealth
Last outcome measure	PASS-21 <input type="checkbox"/> K10 <input type="checkbox"/> K5 <input type="checkbox"/> SDQ Score: <u>46/17</u> Date Administered: <u>10/7/25</u>		
Diagnosis	(Provisional) PTSD, Rage, Stress.		
KEY SUPPORTS: Patient has given consent for GP/Provider to contact support person(s) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name:		Phone:	
Relationship to patient:			
Name:		Phone:	
Relationship to patient:			
OTHER MENTAL HEALTH PROFESSIONALS CURRENTLY INVOLVED (e.g. psychiatrist, social worker)			
Name:		Phone:	
Name:		Phone:	

GP Signature or Stamp:

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**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

M. White

Date

10/7/25

Consent for Patient under 18 years of age:

Parent/Guardian/Carer Name:

Contact number:

Email:

Signature

Date

**Current Medications:**

Drug Name	Strength	Dosage	Reason	Last script
COLECALCIFEROL Oral Liquid (Colecalciferol)	1,000 units (25mcg)/0.5 mL	1mL /2k IU daily m.d.u.	Vitamin D deficiency	19/09/2024
FERRO-LIQUID Oral Liquid (Ferrous sulfate)	30mg/mL	mane ideally at least 1 hour before breakfast without food or drink	Iron deficiency - anaemia	20/02/2025
LEVONORGESTREL/ETHINYLESTRADIOL Tablet (Levonorgestrel/Ethinylestradiol)	100mcg/20mcg [21] + Inactive [7]	1 daily m.d.u.	Premenstrual dysphoric disorder	10/07/2025

Should any of the above need clarification, please feel free to contact me on Telephone 0245767499, or E-mail me at

Thank you for your care and assistance. I look forward to hearing the outcome of Michelle's attendance.

Yours sincerely,



Dr Philip Dalley.