

**BETTER OUTCOMES IN MENTAL HEALTH
FOCUSED PSYCHOLOGICAL STRATEGIES**

- REFERRAL FORM

Version 7 - 2011

Referral Date:		
GP Name:		
GP Contact Details:	Ph:	Mob:
Patient Name:		
Patient DOB:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
Unique Identifier: (Psychologist to enter)	Has the patient signed the consent form? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Patient Address:		
Patient Phone:		
Language spoken at home:	<input type="checkbox"/> English Only <input type="checkbox"/> Unknown <input type="checkbox"/> Italian <input type="checkbox"/> Greek <input type="checkbox"/> Cantonese <input type="checkbox"/> Arabic <input type="checkbox"/> Mandarin <input type="checkbox"/> Vietnamese <input type="checkbox"/> other _____	
How well does the patient speak English?	<input type="checkbox"/> Very well <input type="checkbox"/> Well <input type="checkbox"/> Not well <input type="checkbox"/> Not at all <input type="checkbox"/> Is an interpreter required <input type="checkbox"/> Unknown	
Is the person of Aboriginal or Torres Strait Islander Origin	<input type="checkbox"/> No <input type="checkbox"/> Yes, Aboriginal <input type="checkbox"/> Yes, Torres Strait Islander <input type="checkbox"/> Unknown	
Highest Level of Education Completed:	<input type="checkbox"/> Primary or below <input type="checkbox"/> Secondary – yr 10 or equivalent <input type="checkbox"/> Secondary – yr 11 or equivalent <input type="checkbox"/> Secondary – yr 12 or equivalent <input type="checkbox"/> Tertiary <input type="checkbox"/> Unknown	
Patient Resides With:	<input type="checkbox"/> Alone <input type="checkbox"/> Family/carers <input type="checkbox"/> Friend <input type="checkbox"/> Unknown	
Is patient a low income earner?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
History of Previous Specialist Mental Health Care:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Action To Be Taken:	<input type="checkbox"/> Please contact patient – consents to message being left <input type="checkbox"/> Patient will contact for appointment	
Referral Type	<input type="checkbox"/> Perinatal Depression <input type="checkbox"/> Homelessness <input type="checkbox"/> Remote locations/Indigenous communities <input type="checkbox"/> Children	

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Reason for Referral:	<input type="checkbox"/> Alcohol and Drug Use Disorders <input type="checkbox"/> Psychotic disorders <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety disorders <input type="checkbox"/> Unexplained somatic disorders <input type="checkbox"/> Neurosthenia <input type="checkbox"/> Hyperkinetic (attention deficit) disorder <input type="checkbox"/> Drug Use disorders <input type="checkbox"/> Chronic psychotic disorders <input type="checkbox"/> Acute psychotic disorders <input type="checkbox"/> Sexual disorders <input type="checkbox"/> Bereavement disorder <input type="checkbox"/> Panic disorder <input type="checkbox"/> Mixed Anxiety and Depression <input type="checkbox"/> Phobic disorder <input type="checkbox"/> Sleep Problems (mental health related) <input type="checkbox"/> Adjustment disorder <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Eating disorder <input type="checkbox"/> Conductive disorder <input type="checkbox"/> Disassociative disorder <input type="checkbox"/> Enuresis <input type="checkbox"/> Mental Disorder, not otherwise specified
Focused Psychological Strategy Patient Referred for:	<input type="checkbox"/> Diagnostic Assessment <input type="checkbox"/> Psycho-Education <input type="checkbox"/> Cognitive Behavioural Therapy <ul style="list-style-type: none"> • <input type="checkbox"/> Behavioural interventions • <input type="checkbox"/> Cognitive interventions • <input type="checkbox"/> Relaxation strategies • <input type="checkbox"/> Skills training • <input type="checkbox"/> Other CBT interventions (please specify) _____ <input type="checkbox"/> Interpersonal Therapy <input type="checkbox"/> Other (please specify) _____
Psychotropic Medication Patient is Receiving:	<input type="checkbox"/> None <input type="checkbox"/> Benzodiazepines & anxiolytics <input type="checkbox"/> Antidepressants <input type="checkbox"/> Phenothiazines & major tranquilisers <input type="checkbox"/> Mood Stabilisers
Proposed Mental Health Plan:	PLEASE ATTACH COPY (note referral under this program cannot proceed until this has been completed)
Suggested date for Review of Patient:	
Suggested Date for Practice Visit for Mental Health Plan/Review:	
GP Signature:	

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Please choose the service provider you wish to refer to and fax this form directly to them on the number provided.

TAREE / FORSTER

CLINICAL PSYCHOLOGY SOLUTIONS

90 Albert Street

TAREE NSW 2430

Ph: 02 6552 4180

Fax: 02 6552 4521

UPPER HUNTER

AUSPSYCH

Located at the following:

Scone Medical Centre 5 Surman Street, Scone NSW 2337

Hill Street Serviced Offices 28 Sowbery Street, Muswellbrook NSW 2333

Fairholme Surgery 16 Broughton Street, Singleton NSW 2330

Dangar Medical Practice 33 Dangar Road, Singleton NSW 2330

Singleton Medical Centre 4/122 George Road, Singleton NSW 2330

Ph: 02 4926 1688

Fax: 02 4926 1788

DUNGOG / CESSNOCK

LISA SALES PSYCHOLOGIST

Located at the following:

Bram Cottage

8 Mackay Street

DUNGOG NSW 2420

Cessnock Neighbourhood Centre

198-202 Vincent Street (cnr Allandale Road)

CESSNOCK NSW 2325

Ph: 0409 153913

Fax: 02 4934 2728

CESSNOCK

SHARON BOOTH – MENTAL HEALTH NURSE

Located at the following:

Cessnock Medical Centre

204 Wollombi Road

CESSNOCK NSW 2325

Ph: 0417 444037

Fax: 02 4991 4004