Psychological Therapies Program GP Referral

Confirmation of eligibility criteria
(must confirm all ☑)
☐ Resides in Brisbane South PHN region
☐ Evidence of financial disadvantage
☐ Benefit from short-term intervention
☐ Clinical Mental Health (MH) diagnosis
☐ Has/working toward Mental Health Care Plan

Referral Type (☑ **at least one referral type**)
☐ Aboriginal and/or Torres Strait Islander
☐ LGBTIQAP+
☐ Child (0-11 years)
☐ Living in a rural and remote community
☐ Perinatal depression/anxiety (Child<2)
☐ Domestic and family violence
☐ Homelessness (experiencing or at-risk of)
☐ ***Suicide/self-harm prevention*** *-the client has had thoughts about hurting or killing themselves in the past 4 weeks but is not at immediate risk – if Crisis support is required please contact Acute Care Team or Ambulance.*

Referrer Information:

Date of referral:_____

Name of referrer:_____

Profession:_____

Provider No.: _____

Practice name: _____

_____

Phone:_____

Fax:_____

Client consent: You confirm that the person has been informed about and consented to:
☐ information on this referral form being shared with Wesley Mission Queensland, service providers involved in their care and other PHN-commissioned services when indicated
☐ the support person identified on this referral being contacted by the service provider.
☐ information on this referral being shared with Brisbane South PHN for statistical purposes.
☐ de-identified information on this referral form being shared with the Department of Health for statistical purposes.

Client Information
Client full name:_____**DOB:**_____

Preferred name:_____
Pronouns: ☐He/Him/His ☐ She/Her/Hers ☐They/Them/Theirs ☐ Other_____

Gender: ☐Male ☐ Female ☐Transgender Female (Male-To-Female)
☐Transgender Male (Female-To-Male) ☐Non-Binary ☐Other: _____

Sexual Orientation: ☐Straight/Heterosexual ☐Lesbian, Gay, Homosexual
☐Bisexual ☐Don't Know ☐Not Stated ☐Other: _____

Street Address: _____

Suburb: _____**Postcode:**_____

Home Phone: _____**Mobile:**_____
OK to leave message? ☐ **Yes** ☐ **No**

Support Person name: _____

Support Contact: _____**Relationship**:_____

Ethnicity:
☐ Australian ☐ Both Aboriginal and Torres Strait Islander ☐Aboriginal only
☐Torres Strait Islander only ☐ Other:_____

Country of Birth: ☐Australia ☐Other:_____

Main Language Spoken at Home: ☐English ☐Other:_____

Proficiency in English: ☐Not at all ☐Not well ☐Well ☐Very well
☐N/A (<5 years/English First language) ☐Interpreter Required:_____

Marital Status: ☐Never married ☐Married (registered or de facto)
☐Divorced ☐Separated ☐Widowed

Own Primary Source of Income
☐ Nil income
☐ Full Time Paid Employment
☐ Part Time Paid Employment
☐ Disability Support Pension
☐ Other pension / benefit
☐ Compensation payments
☐ Other (e.g. superannuation)

Health Care Card: ☐ Yes - expiry: _____ ☐ No

Housing situation
☐ Sleeping rough / non-conventional
☐ Short-term or emergency
☐ At risk of homelessness
☐ Not homeless

NDIS Participant: ☐Yes ☐No ☐Accessing other disability funding
If yes are Psychosocial supports included in their plan ☐ Yes ☐ No

Contributing factors (☑ all that apply)
☐Chronic disease:_____
☐Serious accident / injury
☐Grief / loss
☐Physical Disability
☐Intellectual disability
☐Divorce or separation
☐Sexual assault / abuse
☐Unable to secure employment
☐ Carer, unpaid
☐Legal / corrections issues
☐Alcohol or drug related problems
☐Gambling / other addiction
☐Discrimination
☐Trauma
☐Bullying and/or harassment
☐Child safety interactions
☐Other, specify: _____

Perinatal Details : Weeks Pregnant _____Weeks Postnatal: _____

This service has been made possible through funding provided by the Australian Government under the PHN Program

At the completion of this referral please fax to (07) 3539 6445 or alternatively via Medical Objects secure messaging to address QW4106000LX Wesley Mission QLD Psychological Therapies. If you have any questions please contact a member of the Psychological Therapies team on (07)3151 3840

Clinical information:

Formal diagnosis of mental health condition:
☐Yes ☐No

In the past 4 weeks, has the client had thoughts about hurting or killing themselves:
☐Yes ☐No

Client has been hospitalised for Mental Health concern in last 12 months:
☐Yes ☐No

Duration of mental health intervention required:
☐Short term ☐Long term ☐ Crisis

How long ago has the client seen a psychologist:
☐Never ☐ < 3 MTHs ☐ 3 - 6 MTHs
☐6 - 12 MTHs ☐ 12 MTHs+

If client has seen a psychologist, under what funding arrangement: ☐Better Access (MBS)
☐ Psych. Therapies Program ☐ Other:_____

GP Mental Health Treatment Plan Developed
☐Yes ☐In process of development

*Note: GPs are **not** required to attach the completed Mental Health Care Plan.*

Reason for referral/presenting concerns:

_____
_____
_____
_____
_____
_____
_____
_____

Outcome tool used (☑ one option)
☐K10, score:_____
☐K5, score:_____
☐SDQ (Parent 4-10 years) score:_____
☐SDQ (Parent 11-17 years) score:_____
☐SDQ (Self 11-17 years) score:_____

Medication (☑ *all that apply*)
Antipsychotics: ☐Yes ☐No ☐Unknown
Anxiolytics: ☐Yes ☐No ☐Unknown
Hypnotics & Sedatives: ☐Yes ☐No ☐Unknown
Antidepressants: ☐Yes ☐No ☐Unknown
Psychostimulants / Nootropics: ☐Yes ☐No

Principal Diagnosis: (☑ **one option**)

Anxiety Disorders:
☐Panic disorder
☐Agoraphobia
☐Social phobia
☐Generalised anxiety disorder
☐Obsessive-compulsive disorder
☐Post-traumatic stress disorder
☐Acute stress disorder
☐Other anxiety disorder

Psychotic Disorders:
☐Schizophrenia
☐Schizoaffective disorder
☐Brief psychotic disorder
☐Other psychotic disorder

Substance Use Disorders:
☐Alcohol harmful use
☐Alcohol dependence
☐Other drug harmful use
☐Other drug dependence
☐Other substance use disorder

Mood Disorders:
☐Major depressive disorder
☐Dysthymia
☐Depressive disorder NOS
☐Bipolar disorder
☐Cyclothymic disorder
☐Other affective disorder

Subsyndromal Symptoms:
☐Anxiety symptoms
☐Depressive symptoms
☐Mixed anxiety and depressive symptoms
☐Stress related
☐Other

Childhood & Adolescence:
☐Separation anxiety disorder
☐Attention deficit hyperactivity disorder (ADHD)
☐Conduct disorder
☐Oppositional defiant disorder
☐Pervasive developmental disorder
☐Other disorder of childhood and adolescence

Other Mental Disorders:
☐Adjustment disorder
☐Eating disorder
☐Somatoform disorder
☐Personality disorder

Additional Diagnosis: (☑ **all that apply**)

Anxiety Disorders:
☐Panic disorder
☐Agoraphobia
☐Social phobia
☐Generalised anxiety disorder
☐Obsessive-compulsive disorder
☐Post-traumatic stress disorder
☐Acute stress disorder
☐Other anxiety disorder

Psychotic Disorders:
☐Schizophrenia
☐Schizoaffective disorder
☐Brief psychotic disorder
☐Other psychotic disorder

Substance Use Disorders:
☐Alcohol harmful use
☐Alcohol dependence
☐Other drug harmful use
☐Other drug dependence
☐Other substance use disorder

Mood Disorders:
☐Major depressive disorder
☐Dysthymia
☐Depressive disorder NOS
☐Bipolar disorder
☐Cyclothymic disorder
☐Other affective disorder

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