

GP to complete ALL sections

Referral to be sent directly to the psychologist from the GPNN ATAPS Psychologists Directory

SECTION 1 (Patient identifiable information)

Patient Name	Patient Consent
	I have read the Patient Information and I give consent for my clinical information to be shared with the ATAPS Psychologist. I agree to de-identified information (consisting of Section 2 data) to be transferred to GP Network Northside to be used for evaluation purposes.
Patient Contact Details	
Address:	
Telephone:	Signature: _____

Psychologist to fax de-identified (Section 2) information to GP Network Northside on 9477 8799

SECTION 2 (Patient de-identified information)

Referring GP	Date of Referral	Practice Postcode	GP Provider Number
Patient Demographics	Patient Status	Y	N
Male <input type="checkbox"/> Female <input type="checkbox"/>	Aboriginal <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of birth _____	Torres Strait Islander <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Postcode _____			
Primary Language	Patient Social	Y	N
English <input type="checkbox"/>	Lives alone <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Italian <input type="checkbox"/>	Low income <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Greek <input type="checkbox"/>	At risk of homelessness <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cantonese <input type="checkbox"/>	English Level	Y	N
Mandarin <input type="checkbox"/>	Very well <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arabic <input type="checkbox"/>	Well <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vietnamese <input type="checkbox"/>	Not well <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____ <input type="checkbox"/>	Not at all <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Unknown <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Education	Y	N
	Primary or lower <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Secondary (yr 10) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Secondary (yr 11) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Secondary (yr 12) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Tertiary <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychologist's Billing Details	Psychologist's Name:		
	Phone:		
	Fax:		
Primary Diagnosis	Referred For	Cognitive Behavioural Therapy (CBT)	
*Antenatal depression <input type="checkbox"/>	Diagnostic assessment <input type="checkbox"/>	Behavioural interventions <input type="checkbox"/>	GP Mental Health Treatment Plan completed <input type="checkbox"/>
*Postnatal depression <input type="checkbox"/>	Psycho-education <input type="checkbox"/>	Cognitive interventions <input type="checkbox"/>	1 st Referral <input type="checkbox"/>
Alcohol & drug use <input type="checkbox"/>	Interpersonal therapy <input type="checkbox"/>	Relaxation strategies <input type="checkbox"/>	2 nd Referral <input type="checkbox"/>
Psychotic disorders <input type="checkbox"/>	Other: _____ <input type="checkbox"/>	Skills training <input type="checkbox"/>	Outcome Measurement Tool used & Score eg K10
Depression <input type="checkbox"/>		Other: _____ <input type="checkbox"/>	
Anxiety disorders <input type="checkbox"/>			
Unexplained somatic <input type="checkbox"/>			
Other: _____ <input type="checkbox"/>			
Postnatal Depression Group Therapy Sessions			
Postnatal Depression Group Therapy		Psychologist's Name:	
<input type="checkbox"/> Patient would like to attend group therapy		Rhona Barker	
		Telephone: 0422 134 169	
		Fax: (02) 9402 5823	
Perinatal Primary Diagnosis Information			
*If primary diagnosis Antenatal depression please state weeks gestation _____			
*If primary diagnosis Postnatal depression please state age of infant _____			
Medications	Psychologist's Reference	GPNN Voucher Number	
Benzodiazepines & Anxiolytics <input type="checkbox"/>			
Phenothiazines and Tranquillisers (such as risperidone, olanzapine, chlorpromazine, haloperidol, clozapine) <input type="checkbox"/>			
Antidepressants (such as SSRIs, SNRIs, TCAs) <input type="checkbox"/>			
Mood Stabilisers (such as lithium carbonate, sodium valproate or carbamazepine) <input type="checkbox"/>			