



## Mid North Coast Division of General Practice GP ATAPS REFERRAL FORM 2011-2012

<b>Date of Referral:</b>		<b>GP Postcode:</b>	
<b>Patient Name:</b>			
<b>Patient Address &amp; Postcode:</b>			
<b>Patient Telephone:</b>	<b>(H)</b>	<b>(W)</b>	<b>(Mob)</b>

GP Mental Health Treatment Plan (Item 2710/2702) completed (attach)	<input type="checkbox"/> YES <input type="checkbox"/> NO	DATE: _____
Proposed review date (Item 2712) between 4 wks and 6 mths	_____	
Name of Provider referred to (choose from Provider List)	_____	
Has Patient been referred before	<input type="checkbox"/> YES <input type="checkbox"/> NO	

<b>DOB</b>	<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Language spoken at home</b>	<input type="checkbox"/> English <input type="checkbox"/> Other (please specify) _____
<b>How well is English spoken</b>	<input type="checkbox"/> Very Well <input type="checkbox"/> Well <input type="checkbox"/> Not Well <input type="checkbox"/> Not at all
<b>Does the Patient identify as</b>	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Neither <input type="checkbox"/> Unknown
<b>Does the Patient live alone</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>Is the Patient a low income earner</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>Education level completed</b>	<input type="checkbox"/> Primary or below <input type="checkbox"/> Year 7/8/9 <input type="checkbox"/> Year 10 <input type="checkbox"/> Year 11 <input type="checkbox"/> Year 12 <input type="checkbox"/> Tertiary
<b>Prior Mental Health Care</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Comment: _____

Primary Diagnosis	Strategy Check all that are relevant	Current Psychotropic Medication Check all that are relevant
<input type="checkbox"/> F1 Alcohol/Drug Use <input type="checkbox"/> F2 Psychotic Disorder <input type="checkbox"/> F3 Depression <input type="checkbox"/> F4 Anxiety <input type="checkbox"/> F5 Unexplained Somatic <input type="checkbox"/> Perinatal Depression  <input type="checkbox"/> Other: _____	<input type="checkbox"/> Diagnostic Assessment <input type="checkbox"/> Psycho-education <input type="checkbox"/> Interpersonal Therapy <input type="checkbox"/> Narrative Therapy <input type="checkbox"/> Family Therapy <input type="checkbox"/> Behavioural Interventions <input type="checkbox"/> Cognitive Interventions <input type="checkbox"/> Relaxation Strategies <input type="checkbox"/> Skills Training  <input type="checkbox"/> Other: _____	<input type="checkbox"/> None <input type="checkbox"/> Benzodiazepines & Anxiolytics <input type="checkbox"/> Antidepressants <input type="checkbox"/> Phenothiazines & Tranquillisers <input type="checkbox"/> Mood Stabilisers  <input type="checkbox"/> Other: _____

<b>ATAPS Stream</b>	<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Perinatal	<input type="checkbox"/> Aboriginal and Torres Strait Islander People
<b>OUTCOME MEASURE USED:</b>	<b>Scores:</b>		

**GP STAMP**

**MENTAL HEALTH TREATMENT PLAN ATTACHED:**  YES  NO