GP Mental Health Treatment Plan Review - MBS Item 2712

FAX TO: **8408 1699**

Date: WITHIN SIX MONTHS OF ORIGINAL 2700,2701 / 2715, 2717	_ _ / _ _ / _ _

Patient Name: **Contact Details:**				**DASS Outcome Tool Results ⇨**	*Depression* …….. *Anxiety* …….. *Stress* ……
DOB:		**Gender:**		**Date:**	
GP Name: **Contact details:**					

Problem / Diagnosis	**Goal**	**Progress on Actions and Tasks**
Number 1:		
		…… …… ……
Number 2:		
		…… …… ……

Follow-up Relapse Prevention Plan
…… …… …… ……

Re-referral section if further Allied Health Practitioner sessions required: (Maximum of 6 further sessions)
…… …… …… …… ……

Record of Patient Consent:

I, _____ (**patient** name - please print clearly)

Agree to information about my mental health and well being to be shared between the GP and the counsellor(s) to whom I am referred, to assist in the management of my health care.

Signature (patient):_____ **Date:** _____

For Patients under 16 years:

Carer Name:_____ **Carer Signature:** _____

I (GP) have discussed the proposed referral(s) with the patient and am satisfied that the patient understands the proposed uses and disclosures and has provided their informed consent to these.

GP Signature:_____ **Date :** _____