medicare local FREMANTLE
Connecting health to meet local needs

GP Referral Form

GP Mental Health Care Plan Completed ☐ Yes

First Name _____ **Surname** _____

Address _____

_____ **Postcode** _____

Mobile _____ **Home Phone** _____

DOB ____/____/____ **Age** _____ **Gender** ☐ Male ☐ Female

Date of Referral ____/____/____

Was this referral for Perinatal Depression treatment? ☐ Yes ☐ No
If yes, please indicate number of weeks pregnant or age of child:
_____

Does the patient speak a language other than English at home?

☐ No, English only spoken ☐ Yes, please specify _____ Is a translator required? Yes or No

How well does the patient speak English?

☐ Very well ☐ Well ☐ Not well ☐ Not at all ☐ Unknown

Is the person Aboriginal or Torres Strait Islander origin?

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Unknown

Does the patient

☐ Live alone ☐ With partner ☐ With family ☐ With friend or carer

Is the patient a low-income earner?

☐ Yes ☐ No ☐ Unknown

What is the highest level of education the patient has completed?

☐ Primary ☐ Secondary – Yr. _____ ☐ Secondary – Yr. 11 ☐ Secondary – Yr. 12 ☐ Tertiary

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ICD 10 Primary care diagnostic categories

☐ F1 – Alcohol & Drug Use ☐ F2 – Psychotic Disorders ☐ F3 – Depression ☐ F4 – Anxiety
☐ F5 – Unexplained somatic complaints ☐ Other ☐ Unknown

For which focussed psychological strategy is the person being referred?

☐ Intervention as determined by Mental Health Professional
☐ Diagnostic assessment
☐ Interpersonal therapy
☐ Cognitive behavioural therapy
☐ Psycho-education
☐ Other (please specify)

☐ Behavioural interventions
☐ Cognitive interventions
☐ Relaxation strategies
☐ Skills training
☐ Other CBTInterventions (please specify)

_____ _____

Is the patient receiving psychotropic medication? ☐ Yes ☐ No If Yes, please specify below

☐ Mood stabilisers _____ ☐ Antipsychotics _____
☐ Antidepressants _____ ☐ Minor tranquillisers _____

Has the patient been receiving other medication? ☐ Yes ☐ No If yes, please specify below

_____

Has the patient received past mental health care? ☐ Yes ☐ No If yes, please specify below

_____

RISK CONCERNS Are you aware of any potential situations or issues (e.g. anger, aggression, violence) with this patient that may put Mental Health Professional/Staff/Public at risk of harm? Yes ☐ No ☐

Presenting issues

_____

_____

_____

Relevant medical and family history

_____

_____

_____

Recent stressors

_____

_____

_____

Other relevant information

_____

_____

_____

Suicide risk factors

_____

_____

_____

Other mental health professionals involved

_____

_____

_____

Thank you this will allow us to plan appropriate precautions. Call the Fremantle Medicare Local for any questions.

Any enquiries please contact Fremantle Medicare Local on 9319 0555

Patient co-payment per session ☐ Free – Financial Hardship ☐ $10 – Concession Card Holder

$30 – Waged ☐

GP Stamp

GP Postcode

Fax this referral to Fremantle Medicare Local 08 9339 8355

Fremantle Medicare Local will contact your patient to arrange their first appointment