Psychological Strategies (formerly known as ATAPS)

GP request for a second set of sessions or exceptional circumstances

Date:

1. CLIENT DETAILS

Name: _____

D.O.B: _____ Gender: _____

Phone: _____

Address: _____

Next of kin: _____ Phone: _____

2. CONSENT

☐ Client/parent/guardian consent to referral and for transfer of referral documentation to appropriate service provider.

☐ Your client consents to their/ their child's de-identified information being used by EMPHN for evaluation and reporting purposes to the Department of Health. They understand this data, which does not include their name, address or Medicare number, but will include information such as date of birth, gender and types of services they use, will be used for the purposes of improving health services in Australia. Your client understands that their/ their child's information will not be provided to the Department of Health if they indicate they do not consent.

Allied Health Professional (AHP) Name _____

3. REFERRER DETAILS

Name: _____

GP /Psychiatrist Provider Number (where appropriate):_____

Position and organisation: _____

Phone: _____ Fax: _____

Address: _____

_____ Postcode: _____

OR insert your practice stamp here

Fax this completed form to 8677 9510. For any questions, please call 9800 1071.

Is the client high risk or needing crisis intervention? ☐ Yes ☐ No

IF YOUR CLIENT IS PRESENTING IN AN ACUTE PSYCHIATRIC CRISIS OR IF RISK IS HIGH, PLEASE CALL YOUR LOCAL AREA MENTAL HEALTH SERVICE

Is the client low income? ☐ Yes ☐ No

4. EXECEPTIONAL CIRCUMSTANCES (if this re-referral is due to exceptional circumstances please outline these below as per criteria outlined at http://www.emphn.org.au/page/programs/mental-health/access-to-allied-psychological-services-ataps-new/)

_____

_____

_____

_____

_____

I have received a written progress report from the AHP ☐ Yes ☐ No

(AHPs are required to provide a written report to you after the first set of six sessions and/or the end of treatment)

I have undertaken mental health treatment plan review with my client ☐ Yes ☐ No

Fax this completed form to 8677 9510. For any questions, please call 9800 1071.