

\* = MANDATORY FIELDS Patient Key: \_\_\_\_\_ (CHGPN Use Only)

Client No. \_\_\_\_\_ \* Referred by \_\_\_\_\_ \* Referring Date \_\_\_\_\_

\* Referral Type:  General ATAPS  Perinatal Depression  Bushfire ATAPS  Suicide Prevention  
 Homelessness  Aboriginal & Torres Strait Islander  Rural & Remote  Children

K10/DAS Pre: \_\_\_\_\_ K10/DAS Post: \_\_\_\_\_ Client Post code: \_\_\_\_\_

Gender:  Male  Female Due/Birth Date: \_\_\_\_\_ GP Post code: \_\_\_\_\_

\* Does the client live alone:  Yes  No  Unknown \* Is the Client a low income earner?  Yes  No  Unknown

Primary Language spoken:  English or  Other \_\_\_\_\_

If English is **NOT** the primary language, how well does the Client speak English?

Very Well  Well  Not Well  Not at all  Not known

Is the Client -  Aboriginal  Torres Strait Islander origin?  Not Known  No

Client's highest level of education completed:  Primary or below  Secondary, Year \_\_\_\_\_  Tertiary

**REFERRAL DETAILS:**

\* Has the Client ever received specialist mental health care before (public/private medical/allied health)?  
 Yes  No  Unknown

**ICD-10 primary care diagnostic categories (Multiple Responses If Applicable)**

- |  |   |
|--|---|
| <input type="checkbox"/> F1 Alcohol & Drug use disorders | <input type="checkbox"/> F4 Anxiety disorders             |
| <input type="checkbox"/> F2 Psychotic disorders          | <input type="checkbox"/> F5 Unexplained somatic disorders |
| <input type="checkbox"/> F3 Depression                   | <input type="checkbox"/> No Formal Diagnosis              |
| <input type="checkbox"/> Unknown                         | Other Diagnosis _____                                     |

**Referred for which strategies: (Multiple Responses If Applicable)**

- Diagnostic Assessment
  - Psycho-education
  - Interpersonal Therapy
  - Narrative Therapy
- Other: \_\_\_\_\_

**Cognitive behavioural therapy (CBT) (Multiple Responses If Applicable)**

- |  |  |
|--|--|
| <input type="checkbox"/> Behavioural interventions | <input type="checkbox"/> Cognitive interventions |
| <input type="checkbox"/> Relaxation strategies     | <input type="checkbox"/> Skills training         |
- Other CBT interventions \_\_\_\_\_

**Receiving Psychotropic Medication (Multiple Responses If Applicable)**

- Benzodiazepines & Anxiolytics
- Antidepressants (e.g. SSRIs, SNRIs, TCA's)
- Mood stabilisers
- Phenothiazines & Tranquilisers (such as risperidone, olanzapine, chlorpromazine, haloperidol, clozapine)

Were Additional Sessions Required?  Yes  No  Unknown

Conclusion:  Treatment Complete  Patient Could Not Be Contacted  Patient Refused Treatment  
 Patient Referred Elsewhere  Treatment Incomplete but Referral Closed

**Session Date** \_\_\_\_\_  
**Co Payment Amount** \_\_\_\_\_  
**Session Type** :  Group  Individual  
**Duration**:  0 – 30 mins  31 – 45 mins  46 – 60 mins  
 Over 60 mins  No Show  
 Face to Face  Telephone  Video Conferencing  
 Web Based  Case Conferencing

**Strategies Provided:**  
 Diagnostic Assessment  Psycho-education  
 Interpersonal Therapy  Narrative Therapy  
 Other \_\_\_\_\_  
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