ACCESS TO ALLIED PSYCHOLOGICAL SERVICES (ATAPS)

To be completed by the GP and returned to Mental Health Program Manager
By fax: 9979 7834 or post to MWDGP, C/- Mona Vale Hospital, Coronation Street, Mona Vale NSW 2113

Referral Notification Details: **(To be completed by GP)**

Referral Date: / /2010 Is this a re referral? Yes No
(Note: This is the date of the consultation)

Referral Type? **TIER 1** General ATAPS ☐ **TIER 2** Perinatal Depression ☐

Referring GP: _____ Practice Postcode: _____

Patient Details: **(To be completed by patient)**

Patient Name:

(Please Print):

Date of Birth: / / **Residential postcode:**

Gender: ☐ Male ☐Female

ATIS Status:

☐ Aboriginal ☐ Torres Strait Islander ☐ No ☐ Unknown

Main Language spoken at home? *(only answer this question if patient has identified that they speak a language other than English)*

_____

How well does the patient speak English?

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

Patient Details for Referral:

Does the patient live on his / her own?

☐ Yes ☐ No ☐ unknown

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

☐ Primary or below
☐ Secondary (year 10 (completed yrs 7,8 or 9 included in this response)
☐ Secondary (year 11 / equivalent)
☐ Secondary (year 12 / equivalent)
☐ Tertiary

Is the patient a low income earner?

☐ Yes ☐ No ☐ unknown

If yes, Healthcare card number:_____

Has the patient ever received specialist mental health care before?

☐ Yes ☐ No ☐ unknown

Eligibility **(To be completed by GP)**

GP Mental Health Treatment Plan Completed ☐:

Psychological Measure: (To be completed by Allied Health)

Outcome Measurement Tool: _____

Score: _____

Clinical details: **(To be completed by GP)**

Antenatal Depression*: State weeks gestation _____ ☐
Postnatal Depression* Child's DOB _____ ☐
Alcohol and drug use disorders ☐
Psychotic disorders ☐
Depression ☐
Anxiety Disorders ☐
Unexplained somatic disorders ☐
Unknown ☐
Other:_____ ☐

* If primary diagnosis Antenatal depression

_____

* If primary diagnosis Postnatal depression

_____

Group Program referred for:

Diagnostic Assessment ☐
Psycho-education ☐
CBT Behavioral Intervention ☐
Cognitive Intervention ☐
Relaxation Strategies ☐
Skills Training ☐
Other CBT Interventions ☐

Please Specify: _____

_____

Interpersonal Therapy ☐
Other Please specify: _____ ☐

_____

Medications

Benzodiazepines / anxiolytics ☐
Antidepressants (Incl. SSRIs, SNRIs and TCAs) ☐
Phenothiazines / Tranquilisers *(resperidone, olanzapine, clozapine, haloperidol, chlorpromazine* ☐
Mood Stabilisers *(incl. lithium carbonate, sodium valproate, carbamzepine)* ☐
Other Please specify: _____ ☐

_____

Revised 2/11/2011