



# 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

Form 2

The patient must read and sign the consent form. The GP must also sign the consent form. This form including referral notification and consent must be returned to the Mental Health Program Manager at MWDGP.

When MWDGP receives these forms, a purchase order will be created and sent to the allied health professional to authorise treatment. Please direct any enquiries to MWDGP by email [lkirov@mwdgp.com.au](mailto:lkirov@mwdgp.com.au) or phone to 9979 7825

## PATIENT PRIVACY and CONSENT FORM

Your GP has referred you to the Manly Warringah Division of General Practice for participation in the ATAPS Program. Participation in this program will require your GP to provide some information to the allied health professional facilitating the program about your treatment and vice versa.

For the purpose of evaluation and reporting, some of your personal information including name and date of birth, as well as information about the type of mental health concern you are experiencing will be recoded. Some of this information will be provided to the Australian Government Department of Health and Ageing, who are funding this program. Please note that identifying information such as your name and date of birth will not be passed on.

Manly Warringah Division of General Practice is committed to providing you with the highest level of confidentiality and customer service; this includes protecting your privacy.

Manly Warringah Division of General Practice is bound by the Commonwealth Privacy Act 1988, which outlines the principles concerning the protection of your personal information.

### RECORD OF PATIENT CONSENT:

Please tick to indicate who is consenting to collection, use and disclosure of personal health information.

- Patient is consenting – adult patient  
 Patient is consenting – child / adolescent (parent / guardian consent has not been sought)  
 Patient / Guardian consent – child / adolescent patient

I agree to information about my mental health and well being to be collected, used and disclosed to the allied health provider I am referred to, to assist in the management of my health care.

I am also aware that information (that will not identify me) is being collected and used to assist in the management of the ATAPS program, and I agree to this de-identified data being collected and shared.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent / Guardian Name

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date

I have discussed the proposed referral to an allied health professional with the patient and / or parent/guardian and am satisfied that the patient and/or parent/guardian understand the proposed collection, use and disclosures of personal health information and has provided consent to these.

\_\_\_\_\_  
GP Name

\_\_\_\_\_  
GP Signature

\_\_\_\_\_  
Date

**\*\* PLEASE RETURN THIS FORM WITH ALL SECTIONS COMPLETED TO ENSURE THE REFERRAL OCCURES AS SOON AS POSSIBLE**