GP MENTAL HEALTH TREATMENT PLAN

Patient details		Outcome Tool (If used please attach)	Score
Name			
DOB			
Address			
Phone			
Medicare Number			

GP details		Date Plan completed:	
GP name			
Provider number			
Practice name			
Address			
Phone			
Fax			

Assessed Condition
Requested intervention
CBT/ Supportive psychotherapy/other
Emergency Care (as required)
ACIS contact is 131465 for emergencies and after hours contact: Other participants in this mental health care plan:

Client Education
GP has discussed the following with the client: • Assessment and diagnosis of the mental health condition • Main referral options • Goals and benefits of referral • A review date

- **My GP has explained the purpose and details of this GP Mental Health Treatment Plan, and I consent to the creation of a mental health care plan, in my name.**
- **I give permission for my GP and psychologist and any other party named in this plan to exchange their plans and my personal information to provide coordinated care as a treating team.**
- **I understand I am being referred to a private clinic and fees will apply**
- **I understand this referral entitles me to a rebate on my initial 6 sessions.**
- **I consent to Adelaide Psychological Services contacting me to arrange an appointment time**

Client signature		**Date:**
GP signature		**Date:**

Date for Mental Health Treatment Plan Review (between 1 - 6 months) / /

Notes:

**** Fax this form and Assessment to Adelaide Psychological Services: FAX 8295 4170 ****
Adelaide Psychological Services will phone the client to make an appointment