



## South Eastern Sydney Division of General Practice Ltd

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### ATAPS Referral Form

GP to complete ALL sections and send to selected ATAPS service provider from the SESDGP ATAPS Directory with referral letter and completed Mental Health Treatment Plan

<b>Patient Name</b>	<b>Patient Consent</b>  <i>I have read the patient information and I give consent for my clinical information to be shared with the A TAPS Service Provider. I agree to de-identified information to be provided to South Eastern Sydney Division of General Practice for project evaluation.</i> <b>Signature:</b>
<b>Patient Contact Details</b>	
Address:  Telephone:	

<b>Have you completed a GP Mental Health Treatment Plan?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Have you given the patient an ATAPS Patient Information Leaflet?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Have you received an ATAPS referral number from SESDGP?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>ATAPS referral number and date:</b>	<b>Date:</b>
<b>Name of Provider referred to:</b>	
<b>Phone contact:</b>	<b>Fax:</b>

#### Patient's Details for De-Identified Reporting

<b>Year of birth</b>		<b>Gender</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Main language spoken at home</b>	<input type="checkbox"/> English <input type="checkbox"/> Other	(Please specify):	
<b>How well do they speak English?</b>	<input type="checkbox"/> Very Well <input type="checkbox"/> Well <input type="checkbox"/> Not Well <input type="checkbox"/> Not at all		
<b>Is the patient:</b>	<input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Aboriginal <input type="checkbox"/> Neither <input type="checkbox"/> Unknown		
<b>Education Level</b>	<input type="checkbox"/> Primary or below <input type="checkbox"/> Year 7.8.9.10 <input type="checkbox"/> Year 11 <input type="checkbox"/> Year 12 <input type="checkbox"/> Tertiary		
<b>Do they live alone:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>Low income earner?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>Prior mental health care?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

<b>Primary Diagnosis:</b>	<b>Referred for:</b> (please select all that apply)	<b>Is the patient receiving psychotropic medication?</b> (please select all that apply)
<input type="checkbox"/> Alcohol/Drug Use <input type="checkbox"/> Disorder Anxiety <input type="checkbox"/> Psychotic Disorder <input type="checkbox"/> Depression <input type="checkbox"/> Somatic Disorder <input type="checkbox"/> Unknown Comorbidity:  <input type="checkbox"/> Other:	<input type="checkbox"/> Diagnostic Assessment <input type="checkbox"/> Psycho-education <input type="checkbox"/> Interpersonal Therapy <input type="checkbox"/> Behavioural Intervention <input type="checkbox"/> Cognitive Intervention <input type="checkbox"/> Relaxation Strategies <input type="checkbox"/> Skills Training <input type="checkbox"/> Narrative Therapy <input type="checkbox"/> Other:	<input type="checkbox"/> None <input type="checkbox"/> Benzo/Anxiolytic <input type="checkbox"/> Anti-Depressant <input type="checkbox"/> Tranquilisers <input type="checkbox"/> Mood Stabilisers <input type="checkbox"/> Additional.Other:

<b>ATAPS Stream</b>	<input type="checkbox"/> DepAnxSt (use DASS21)	<input type="checkbox"/> Self Harm Service Provider - administer MSSl	<input type="checkbox"/> Perinatal (use EPDS)
<b>DASS 21 Pre Scores</b>	Depression:	Anxiety:	Stress:
<b>Edinburgh Pre Scores (EPDS):</b>			