



GP Links Wide Bay
Access to Allied Psychological Services (Better Outcomes) Referral
 Fax: 4151 0794

Client Details

Re: _____
 Address: _____
 DOB: _____
 Home Phone: _____
 Mobile Phone: _____

Date: _____

Referral From

Name: _____
 Address: _____
 Usual GP (if different from above): _____

Specific Referral for: PND / Climate-related / Children / Rural / General (please circle if applicable)

If client has had **previous** psychological counseling, give name of clinician? _____

Criteria: Is this client a low income earner? Yes / No

Mental Health Treatment Plan? Date completed: ___ / ___ / ____

Referral Details

Primary Care Diagnosis:

ICD-10 Primary Care Diagnostic Categories (multiple responses permitted)

<input type="checkbox"/>	F1	Alcohol & Drug Use Disorders
<input type="checkbox"/>	F2	Psychotic Disorders
<input type="checkbox"/>	F3	Depression
<input type="checkbox"/>	F4	Anxiety Disorders
<input type="checkbox"/>	F5	Unexplained somatic disorders
<input type="checkbox"/>		Unknown
<input type="checkbox"/>		Other:

Focused psychological strategies required? (multiple responses permitted)

<input type="checkbox"/>	Diagnostic Assessment
<input type="checkbox"/>	Psycho-education
<input type="checkbox"/>	Interpersonal Therapy
<input type="checkbox"/>	Other:

Cognitive-behavioural Interventions:

<input type="checkbox"/>	Cognitive interventions
<input type="checkbox"/>	Behavioural interventions
<input type="checkbox"/>	Relaxation Strategies
<input type="checkbox"/>	Skills Training
<input type="checkbox"/>	Other:

Scores:

K10 / DASS / EPDS: _____